DOCUMENT RESUME

ED 057 346 AC 012 207

AUTHOR	Blake, Robert R., Ed.; Wolfe, Suzanne, R., Ed.
TITLE	International Workshop on Communications in Family Planning Programs (Teheran, June 6-18, 1970). Final Report.
INSTITUTION	North Carolina Univ., Chapel Hill. Carolina Population Center.
SPONS AGENCY	Ford Foundation, Beirut (Lebanon). Middle East Office.; Ministry of Health (Iran).
PUB DATE	71
NOTE	177p.
EDRS PRICE	MF-$0.65 HC-$6.58
DESCRIPTORS	Changing Attitudes; Clinics; *Communications; Conferences; Educational Programs; *Family Planning; *Information Dissemination; *Policy Formation; Population Growth; Problem Solving; Questionnaires; Simulation; *Workshops
IDENTIFIERS	Africa; Iran; Middle East; *Teheran

ABSTRACT

This report presents some of the proceedings of a workshop on communications in family planning programs held in Teheran, Iran. A total of 82 participants from 15 Mid-Eastern and African countries attended. The purpose of the workshop was to assist each country to prepare a work plan for information and education activities related to population programs. A major feature of the workshop was the development and use of two simulation exercises. The first exercise describes a country called "Arcadia," which had no population policy and no real interest in developing a population program. With the help of resource advisors, country teams were systematically lead through the educational problem: setting clear objectives and deciding program strategy for achieving objectives. The second exercise described a country called "Valhalla," which had a stated policy to reduce population growth rates and a large number of established clinics, largely unused. Again, conference participants worked at solving the problem of information dissemination and changing attitudes. After the completion of the two simulation exercises, country work plans were developed with the help of a questionnaire completed by the delegates prior to their arrival in Teheran. (Author/CK)

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ED057346

FINAL REPORT

INTERNATIONAL WORKSHOP ON COMMUNICATIONS IN FAMILY PLANNING PROGRAMS

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ED057346

FINAL REPORT

INTERNATIONAL WORKSHOP ON COMMUNICATIONS IN FAMILY PLANNING PROGRAMS

TEHERAN, IRAN

6 THROUGH 18 JUNE, 1970

ROBERT R. BLAKE
EDITOR

SUZANNE R. WOLFE
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Sponsored by

Family Planning Division
Ministry of Health
Government of Iran

The Ford Foundation
Middle East Regional Office
Beirut, Lebanon

Carolina Population Center
University of North Carolina
Chapel Hill, N.C.

Published by The Carolina Population Center, University of North Carolina, Chapel Hill, 1971.

ACKNOWLEDGEMENTS

For any success achieved by the Teheran workshop, primary credit should be given to the large number of people from the Iranian Ministry of Health who worked so tirelessly on workshop organization. I especially want to thank H. E. Dr. Amir M. Sardari, Dr. Khalil Asayesh, and Dr. Ali Zahedi, who carried the major burden for conference arrangements. Their lieutenants in this effort included Dr. Masood Khatamee, Mr. Tofigh Ghafoori, Dr. Bahram Mohit, and Dr. Khosrow Farhang.

I also wish to thank Mr. A. A. Gaffary, Head, Conference Department, Iranian Centre for International Conferences, and his colleagues who handled transportation and translations and provided secretarial assistance. Dr. John Friesen and Mr. Robert Gillespie, Population Council representatives in Iran, provided much needed assistance in the planning stages and also served as Chief Resource Advisors to the Iranian delegation.

The conference was funded by the Middle East Office of The Ford Foundation, Beirut, Lebanon. The encouragement and support of Mr. J. Donald Kingsley, Ford Foundation Representative, is gratefully acknowledged.

Further, I want to express my warm appreciation to my assistant, Mrs. Suzanne Wolfe, who accepted major organizational responsibilities during the conference. The preparation of the two simulation exercises is largely the work of Mrs. Wolfe.

Finally, I wish to acknowledge the skilled editorial assistance of Mrs. Bonnie Powell in compiling this report.

ROBERT R. BLAKE
Chapel Hill

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INTRODUCTION

This report presents some of the proceedings of a workshop on communications in family planning programs held in Teheran, Iran, from June 6 through June 18, 1970. The workshop was sponsored by the Iranian Ministry of Health, the Carolina Population Center, and was funded by the Middle East Office of The Ford Foundation, Beirut, Lebanon.

A total of eighty-two (forty-seven from Iran) participants from fifteen Mid-Eastern and African countries attended the workshop. Through a special request of the Agency for International Development (Washington, D.C.) a delegation from the Philippines also participated. Six observers from international agencies attended, along with ten resource advisors from four countries. Thirteen Iranian resource advisors participated. A complete list of delegates and resource advisors is provided in Appendix A.

The purpose of the workshop was to assist each country to prepare a work plan for information and education activities related to population programs. A secondary purpose was to clarify to delegates the importance of these activities in their population programs. We feel the first objective, was pretty well achieved– plans were completed by all country teams. In addition, three provincial plans were developed for Iran, including an experimental research design for the Ishfahan communications research project.

One noteworthy feature of the workshop was the development and use of two simulation exercises. The first exercise describes a country called "Arcadia" which had no population policy and no real interest in developing a population program. After reading a fairly extensive description of Arcadia, participants were asked: "What should the information and education officer of the Family Planning Association of Arcadia be doing?" With the help of resource advisors, country teams were systematically lead through the educational problem: setting clear objectives; deciding pro-

gram strategy for achieving objectives; selecting target groups; listing activities to reach the target groups and finally; the scheduling of activities on a monthly basis.

The second simulation exercise described a country called "Valhalla," which had an entirely different educational problem. Valhalla has a stated policy to reduce population growth rates; it also has a large number of established clinics, largely unutilized. Valhalla's information and education problem is to recruit patients into existing facilities.

It seemed to the organizers that the participants enjoyed working through the above simulation exercises. They were successful probably because they were able to look at problems in Arcadia and Valhalla objectively, without reference to real or imagined barriers. If barriers were brought up ("How much money does the Program Office have to allocate?"), resource advisors simply changed the ground rules. ("Let's assume he has all the money required.")

The simulation exercises, then, were the keystones on which delegates based systematic studies of educational and promotional problems in their own countries.

During the workshop, each day began with the presentation of a major paper. (See Appendix B.) Since papers were distributed to delegates one day prior to presentation, speakers were encouraged *not* to read their papers, but to spend thirty to forty-five minutes discussing major points. Each presentation was followed by a panel discussion, then by floor discussion. Each delegate served on a panel sometime during the conference.

Group sessions, held each afternoon, consisted of four to six delegates and a resource advisor. After completion of the two simulation exercises, country work plans were developed with the help of a questionnaire completed by the delegates prior to their arrival in Teheran.

Two reporting sessions were scheduled during the workshop. On the first day of the conference a representative from each country made a ten-minute presentation describing his country's population policy and its family planning activities, reporting on family planning information and education activities, and describing any special communication problems. On the next to last day of the

workshop, a representative from each country presented a short report on his team's information and education plan.

We believe that most delegates were satisfied with the organization of the workshop. Meetings were held in a new conference building with all necessary amenities, and the program was designed to provide ample time for delegates to discuss points made during the plenary sessions.

Whether or not the workshop achieved the second objective–clarifying the role of information and education in population programs–will be known only after a period of time. If work plans developed at Teheran are implemented in some of the countries, the time, money, and effort will have been well worth the investment.

For the Philippines, Kenya, and Ghana the timing of the workshop was critical. All three of the countries are in the process of planning national population programs. The projects planned in Teheran can be immediately utilized in overall program planning. For Iran, the workshop may prove very useful, since the conference received a good deal of publicity in Teheran newspapers and television stations. And, the strong message of support from His Majesty may make it easier to mount aggressive programs in Iran. Many Iranian delegates were exposed to a number of new ideas.

The workshop also provided an opportunity for delegates from such countries as Ethiopia, Sudan, Tanzania, and Uganda to observe that some of their neighbor countries are seriously concerned about population problems.

Originally the organizers had planned to invite delegates only from the Mid-East and North Africa. However, inquiries from Ford Foundation offices in other African countries indicated there was much interest in the workshop, so the sponsors decided to invite delegates from outside the region.

The real success of such a workshop can be judged only after delegates have returned home and have had time to begin to change information and education activities in their countries. The Carolina Population Center is grateful to the Middle East Office of The Ford Foundation for making the workshop possible.

ROBERT R. BLAKE

THE SHAHANSHAH ARYAMEHR'S MESSAGE

DELIVERED TO THE WORKSHOP, JUNE 6, 1970

On this occasion we express our appreciation that this International Workshop on Communication in Family Planning is taking place in Teheran.

The rapid and unexpected increase of population throughout the world has created a critical situation for humanity. It is up to governments to make the utmost endeavor to urgently study this problem as with each passing day this situation grows more acute.

High population growth rates seriously hamper efforts to raise the standard of living for the individual. In a too rapidly expanding population it is impossible to provide education, health and social services, food, housing, and so on for a rapidly increasing population.

Governments who wish to achieve their social and economic aims in providing for the welfare of society are forced to come to grips with the population problem as one of the essential and fundamental factors in long-term planning.

The threat of present population growth rates throughout much of the world, known as the "population explosion," has been studied internationally during the past decade. Family planning has been proposed as a solution. Investigations have been conducted on this subject in spite of the fact that the problem is a most sensitive one, affecting people's emotions and attitudes.

The achievement of desired results cannot be realized without the full cooperation and support of governments and responsible authorities. In 1967, on World Human Rights Day, we submitted with the heads of state of twenty-nine other countries, a declaration on population to the United Nations and stated our view as follows:

We believe that the population problem must be recognized as a principal element in long-range planning if governments are to achieve their economic goals and fulfill the aspirations of their people.

The various aspects of family planning and the regulating of family size are of paramount importance in the maintenance of human rights. It was, therefore, significant that considerable time was devoted, during the International Conference of Human Rights held in Teheran in 1968, to discussions pertinent to family planning.

The aim of family planning is to provide for and to consolidate the welfare of the family and society. To achieve this vital aim, we need to give careful attention to family size. In other words, the population increase of any society should be compatible with the economic and social conditions of that society.

In our country special attention should be paid to the fact that although we are, fortunately, not facing the difficulties of land shortage or poor agriculture or lack of mineral resources, we are facing a serious limitation, namely a water shortage. Our limited water resources can support only a given number of people; this fact obliges us to carefully plan our future population.

In view of the rapid economic progress in our country, and to ensure the maintenance of proper population size, with respect to economic growth, we ordered in 1967 the implementation of a family planning program. Since its inception, this program has progressed successfully.

Thus, as a result of extensive education, the people of Iran have become aware of the far-reaching social changes occurring in recent years. The program, which was launched in good time in our country, gives us the opportunity to provide an active manpower for our growing economy and industry and thus to assure, in future years, a greater well-being for the people of Iran. This is our hope not only for our nation but for all nations. We, therefore, believe that it is the duty of all governments, and of the United Nations as coordinator, to exert every effort in resolving this challenging world problem.

Editor's Note: *The Shahanshah Aryamehr's message was read to the workshop by H. E. Mr. A. A. Hoveyda, The Prime Minister of Iran.*

THE THINGS WE KNOW ABOUT FAMILY PLANNING INFORMATION

WILBUR SCHRAMM

As a research man, I am in the habit of pointing out how much we do *not* know, but need to know, and consequently how much research we need to do. But several months ago someone said to me, "We don't really know anything about family planning campaigns, do we?" And suddenly, I found myself on the other side of the argument, saying, *of course,* we know a great deal about family planning campaigns, and *certainly* enough to run these campaigns more effectively than we often do.

As a result of that conversation, I began to try to set down some of the things I think we *do* know about family planning campaigns. My little list is certainly incomplete, and any of you, I am sure, could add to it. Because of time limitations, it has to be simple: we know each of these things in greater detail and depth than I can talk about them this morning. I expect that some of you will find the list disappointingly short, and some of you will find it surprisingly long. In any case, I want to share it with you.

Frankly, we do not know how much a full-scale campaign of information and education could contribute to a program of family planning. That has never been tested. No nation on earth has ever given family planning information a full and fair trial. In greater or lesser degree every such program has been restricted by lack of funding, lack of trained personnel, or lack of policy support.

Developing countries typically put one to ten cents per capita per year into family planning, of which 5 to 10 percent goes for information. What if they were to put 25 cents into family planning, and 25 percent of that into information?

A country like Taiwan has managed to put into the field one family planning worker for every 5,000 households, one for every 3,200 women of child-bearing age. This is a very good ratio, but Taiwan recognizes that it must still further increase its worker corps. What would be the effect if there were one worker for each 2,500 women, or 2,000 women, who are prospective clients?

Most of the programs represented in this meeting have information budgets that can be measured in thousands of dollars, and central information staffs that can easily be counted on the fingers of one hand. What if these were doubled or tripled?

We do not know the answers to questions like that. When we speak of what information can do for family planning, therefore, the only evidence we have comes from poorly financed, incompletely developed, and understaffed campaigns, half measures, compromise budgets, and penny-pinching attitudes toward information as a tool. These are bound to be reflected in our data.

Furthermore, we must admit that most family planning campaigns are "flying blind," so far as trustworthy research evidence is concerned. Even pretesting—which is so simple to do and would make so much difference—is seldom used. The only family planning program in the developing regions that has anything like an adequate research and evaluation program is Taiwan, where the Institute of Population Studies, with forty-five college graduates and seventy interviewers, is thoroughly integrated into the operational program. This unit has done a number of useful and competent studies, and as a result Taiwan *does* know something about how its program is working. This information has played no small part in the steady increase of contraception users from 22 percent in 1965 to 34 in 1967 to 44 at the beginning of 1970. But Taiwan is an exception. Nowhere else is there such a store of reliable information through which the effect of family planning campaigns can be evaluated.

Nevertheless, a little stock of information is building up. It comes from research, where that is available, and from field experience, where that has been analyzed. Most of the examples I shall give today come from Asia, where I have spent most of the last three months. This is not so bad because more than half of all the organized family planning in the world is being conducted in Asia. I regret that I have not spent a comparable time examining African

and Middle Eastern Programs, and I hope you will educate me by contributing experience from *your* countries.

Now, what do we know about family planning information?

I have organized this little summary under ten points.

1. *Every highly effective campaign combines three essential elements: services, personal contact, and a broad supporting program of information and education.* By services I mean clinics and distribution of supplies. By personal contact I refer mostly to the field workers. And you know what I mean by the third element.

A deficiency in any one of these three elements weakens the campaign as a whole. Strength in each of the elements contributes to the entire program: the more clinics, the more field workers, the more information that flows, the more success–providing, of course, that quality is maintained, up to a level of saturation that we are far from reaching. Research backs this up. Studies of clinic use show that the proportion of patients declines sharply with distance. Earlier I mentioned the steady growth of acceptors in Taiwan from 25 to 44 percent; it is not altogether a coincidence that in those years the number of field workers rose from 200 to 330 to 400. And, all of us have seen the great upsurge in campaign impact that has resulted from establishing a national policy in support of family planning so that information can flow through public channels.

2. *Where available, the most effective tool of an information and education program is home visits by a competent and motivated family planning worker.* Studies have shown, over and over again, that except for people who are ready and waiting for family planning, it is necessary to help an acceptor take that first difficult step toward the clinic. Beginning with the Song Dong Gu study in Korea, the field worker has consistently emerged as the most efficient force for accomplishing that. Radio is often the most widely used channel of information, but the worker obtains the lion's share of acceptors; she is usually the motivator of community meetings and the most effective agent to follow up program dropouts. Before the clinic, she is likely to have been chief source of information about family planning.

This implies, of course, that she is well-selected, well-trained, and well-motivated. We know quite a bit, now, about how to select a family planning worker. The priority elements seem to be credibility in the eyes of her audience, enough education to learn her job, and a personality type enabling her to get along with people. We know a great deal about how to motivate a field

worker, and I think you would be interested in reading in *Studies in Family Planning*, if you have not already done so, how the quota and incentive systems work in Korea and Taiwan. The same journal published in February 1970 an outline of how a home visit is conducted in one Asian country and what the field worker says under given conditions. Finally, we know a great deal about how to train a field worker. In this conference we have heard some of that; let me also recommend several articles in *Studies in Family Planning*, notably in the December 1968 issue.

Thus far we have been talking about professional, usually full-time, field workers. Is it possible also to use part-time workers, and pay them on the basis of the number of acceptors they get? This has worked in India, Pakistan, Korea, and many other places. The man who has had a vasectomy has proved an effective recruiter in India, and the woman who wears an IUD has proved effective in obtaining other IUD acceptors in Korea. Influential persons in a village, if they will work in the campaign, are also effective. A remarkable study in Korea compared the part-time recruiting of a number of different kinds of individuals, including housewives with or without IUDs, druggists, beauticians, elected neighborhood leaders, and so forth. The housewife with an IUD and the elected neighborhood leader each managed to recruit about sixteen acceptors a month, and the average cost for obtaining each acceptor was about 26 cents as compared to over $4.50 for a full-time worker. It seems clear that part-time workers of this kind can be a useful supplement to full-time workers. But, a Taiwan study holds up a warning: home economics extension workers were paid about 25 U.S. cents for each referral, but there was little result except when the workers were closely supervised. If such supervision is required, obviously the cost is going to go up swiftly.

3. *Field workers, effective as they are, need support from other channels of information and persuasion.* The evidence for this is threefold: the acceptance rate goes up when a program of public information is introduced; many acceptors credit the mass media for a part of the information and motivation that led them to the clinic; and field workers themselves are grateful for media support.

Media comparison studies, however, are very difficult to do in the field. As I read the evidence, however, if I had to put my money in only one medium in developing regions, I should choose radio. This certainly has been true of Asia, partially because of the rapid spread of transistors and the ability of radio broadcasts

to leap the barrier of illiteracy. I should think it would also be true in Mid-Eastern and African countries. Compared with radio, all the printed media are minor as agents of mass coverage, but considerable numbers of literates report reading newspaper and magazine articles on family planning, and they often talk about these articles to persons who do not read them. Posters are seen, family planning symbols are apparently helpful for literates and non-literates alike, and even the elephant that Tyagi and Wilder set to tramping from village to village in India attracted great attention to the program. It takes a lot of elephants, however, to cover India, and I can't quite imagine an elephant tramping over Iran! Leaflets are essential for special purposes. And remember that no experienced campaigner ever limits his information to one channel if he can help it.

It is surprising to me that more use has not been made of existing organizations. In a planning session the other day, we reviewed the information channels available to Tanzania, and it seemed clear that the most hopeful ones were the national women's organization, the national adult education program, and the local organizations and groups that are so well connected, in Tanzania, with higher levels. Some countries have used the military to get information to young men; some are beginning to work with industries. I should expect to see considerably more use of organizations like these, with their built-in channels and their built-in credibility.

Because family planning has been generally considered to be a personal matter, less has been done than might have been to bring social support to bear on acceptors. "Mothers' classes" have been mildly successful in Korea; community meetings have produced results in several countries, although they require a lot of work from the field staff. One wonders, though, whether patterns like the radio rural forum as used in India, Canada, Togo, and other countries could not possibly be adopted to family planning.

Let me say a word about direct mailings. These have generally proved quite effective in obtaining acceptors at low cost when used for groups already disposed to accept. The less selective the mailing list, the higher the cost. But Taiwan was able to obtain acceptors for 65 cents each, when letters were addressed to women who had recently given birth. When special offers are made, or when the campaign is very new, mailings are also likely to be efficient. But at best they do not reach great audiences, and they cannot reach far beyond the literate audience. For example,

in Taiwan the usual rate of response to the letters has been about 4 percent.

4. *Whatever channels are used, we can count on further diffusion by word of mouth.* In one careful study, it was found that holding meetings in *every* township was only 12 percent more effective in obtaining acceptors than holding them in *every other* township and cost twice as much. In the Taichung study, visiting one-fifth of the homes was about as effective as visiting one-third of them. In Thailand, the Chulalungkorn Clinic was visited by a number of women from the far corners of the country, even though no mass communication on family planning was at that time available. It should be pointed out, of course, that these were the women who were ready and eager to respond and who required no special persuasion. The finding is very important, however, because it tells us that we can depend on personal communication to extend our media channels, and that by starting the flow of information we can insure, to some extent, that people will talk about family planning and bring information into the open.

5. *The chief appeals used effectively thus far in family planning campaigns have been health, happy families, and education (chiefly for women), and education and economic betterment (chiefly for men).* I know of no reliable research that compares the effectiveness of these appeals, although program officers have reported favorably on all of them. The theme of "sex without fear," or, as in the ads we heard the other day, "for people who want babies—later," is beginning to be used and ought to be especially effective for young people. Very little widespread use of the theme of national good and environmental exhaustion has been made as yet in the developing countries, but I should expect this to be a major appeal at a later time. The present theory behind the choice of appeals seems to be that arguments directed toward personal or family benefit will be more effective than those related to national or world benefit.

6. *Up to this point, family planning campaigns in the developing countries have been overwhelmingly directed to women, chiefly to those over thirty who already have several children. This focus is now being broadened.* In many countries, an urgent need is currently felt to direct a larger part of the program to young women. For example, the cohort of women fifteen to nineteen, who are just entering the marriage age range in Taiwan, is 750,000 compared to 450,000 in the age group twenty to twenty-four. If these younger women are as productive as those in the four-year

group above them, the birth rate will certainly rise. Furthermore, there seems to be less truth than was originally believed to the idea that women under thirty were resistant to the idea of family planning. There is considerable evidence that they welcome it, particularly in the form of the pill. It is noteworthy that the average girl in the Taiwanese culture now attains her ideal family size by age twenty-five! Not only the younger generation of women, but also men are beginning to seem more important as audiences for family planning information, and are beginning to be approached successfully through organizational memberships.

7. *The most successful ways of countering unfavorable rumors and reducing the dropout rate have proved to be (a) full disclosure of facts from the beginning, (b) continuing information to doctors and other professional personnel, and (c) followup.* In this as in many other fields of persuasion, a two-sided presentation works best when the audience is likely to hear the other side anyway. Continuing information to doctors, nurses, and field workers keeps them up to date and provides a supply of current evidence they can effectively use. Followups by field workers or mail have proved effective in bringing a considerable percentage of dropouts back into the program. When the rumors fly high, it has sometimes proved effective to have doctors, on mass media, discuss the problem of side effects. And one or two countries are trying a telephone service to counter rumors and to provide accurate information when acceptors begin to doubt.

8. *Free offers and special campaign periods are helpful when not overused.* In East Asia where the effects of free offers have been studied carefully, it is estimated that a thirty-day period in which materials or services are offered free will approximately *double* the rate of acceptance for that period. During the next three months, the acceptance level goes down, but then comes back up, and the cumulative total over the space of five or six months is definitely higher than before. If the offer continues much longer, however, or if it is repeated more often than about every six months, there is little extra gain, possibly because the cream is skimmed, or because the field worker saves her best efforts for the special campaign and cannot keep up the pace. Korea's Family Planning Month is a very successful operation, but the Korean officials would not like to do it more than once a year.

9. *Incentives work, under acceptable circumstances.* I am speaking now of incentives offered field workers, or patients, for acceptance, not the long-range type of incentives suggested by

Kingsley Davis and others– for instance, tax credits or limitations on the number of children who can be educated free. So far as I know, the latter have not been tried. However, as we have noted, monetary payments have succeeded, in a number of countries, in enlisting the efforts of part-time workers to recruit patients for family planning clinics. The Philippines is recruiting a number of family planning workers who will get no regular salary, but will receive two pesos for every referral to the clinic, and a third peso if the patient is still in the program six months later. Both Korea and Taiwan have an elaborate quota system which entitles a field worker to a bonus as large as one or two months additional salary every six months if the record is exceptionally good, and, in Taiwan, brings about dismissal if for several consecutive months the performance is low. In India, both the recruiter and the vasectomy patient receive small payments. Several countries provide payment for travel or for expenses and lost income; so far as I know payments to acceptors are always for expenses like these, not direct rewards. These incentives take many forms, and they are generally considered helpful to the program.

10. *In most respects what has been learned about the design of other change compaigns applies also to family planning campaigns.* This is very important, if true, because it means that family planning organizations can benefit from the long experience of marketing, argricultural extension, health and other campaigns, to the extent that these experiences can be applied to a personal and rather sensitive action. This source of knowledge becomes especially useful when family planning has a national policy behind it and can be brought out into the open to use channels of public information. In that situation, a family planning campaign, like other campaigns, must have a focus, a theme, and preferably a symbol. It must have a beginning, a middle, and an end; it must go on long enough to have its effect and give way to another campaign before it becomes boring. It must use a variety of channels, each directed at the audience it can best reach with each carrying the kind of information it can best carry. It must combine repetition with variation. It must make it easy for the "buyer" to obtain the product, if he decides to buy. It must invest enough resources to meet the goal, but make as sure as possible, by pretesting and evaluation, that the money is not being wasted. I think it would greatly benefit many family planning programs to study some commercial or social change campaigns, or to bring in a campaign expert to tell them how he does his job,

and then to decide for themselves what they can learn from the long experience and the considerable research of these other campaigns.

The curve of adoption for family planning, as for television or hybrid corn or the new rice or most other products, goes along slowly for a while, then rises very rapidly until it levels off on a high plateau. In the case of family planning, the rapid rise usually comes when the subject can be brought out into the open and information can flow freely. However, there is an important difference between family planning, on the one hand, and television and hybrid corn on the other. The two latter products reach their plateau at close to 100 percent of possible adopters. The family planning plateau is much lower. Even in the older and better financed programs within the developing world this plateau seems to be between 20 and 40 percent. There are reasons for this, among them the imperfections of contraceptives and the level of development of a country. Yet the fact remains that there is a considerable gap, even in the more advanced programs, between the present level of acceptance and the proportion of women who say that they approve of family planning, and between the present level and the target level which the country feels it must reach. For example, Korea now has about 27 percent of women between fifteen and forty-four as acceptors, and the figure is on a slowly rising plateau. But upwards of 80 percent of women approve of family planning, and Korea feels that it must have at least 45 percent in order to bring its population growth within desirable limits.

What does this mean for information programs? During the first period of swift growth, almost any kind of information campaign will work, if it reaches a large number of people. This is when the "ready and eager" candidates need little more than to be informed of what is available where. However, when this first crop is harvested and when the curve begins to flatten out, then the requirements on information are entirely different. Then, it is necessary to turn special attention to the dropout rate which, in one recent Asian study, was found to be two-thirds of all acceptors for the pill and one-third for the loop, within a year. It becomes highly necessary to reach young women and, if possible, to introduce suitable information into the school curricula. It becomes more important to reach men as well as women. To reach these special audiences and overcome the reluctance of non-acceptors or

dropouts, it is necessary to use sharper tools than in the early stages of the program. It is necessary to have better, more specialized, campaigns and to evaluate carefully what we are accomplishing.

In the very early stages of a family planning program, then, it doesn't make too much difference if we are indifferent to the needs of the information budget and the information staff. For a little while, it does not even make a great difference if we merely establish clinics and let them "speak for themselves." My message to you is that those days are soon gone forever. As the program moves into the stage of a national open policy, and then into the task of trying to raise the plateau, nothing less than a full and skillful use of information channels can possibly meet the goals we must assign ourselves. Anything less will be too little and too late.

COMMUNICATIONS ISSUES

LYLE SAUNDERS

I would like to discuss a few aspects of family planning communications that seem not to have been emphasized so far at the conference. My comments may sound critical or even mildly heretical. We all have prejudices and biases, and mine, as you will hear, tend to be skeptical, pessimistic, and critical. Yours are likely to be different. But since our purpose is to *exchange* views and opinions and not to win converts for any particular point of view, disagreement—at least initially—may represent a necessary step in the process by which we are all learning from each other.

I do not think there is any special mystery or mystique about family planning communications. And I don't think that people in general are any more resistant to family planning ideas and information than they are to any other set of notions. After all, family planning—or, more explicitly, contraceptive practice—is not something new that we have just invented in the last decade or so. As our earliest archaeological records show, people in this part of the world were practicing contraception 4,000 years ago. If they had had better methods, the cradle of history might not have had a baby in it! The passages from the Koran discussed by Dr. Omran (p. 32) indicate that family planning was a topic of conversation thirteen centuries ago. Contraception is a living part of human history, and probably there has never been a society that did not practice some form of family limitation.

If our attempts to promote—or sell, if you will—contraceptive use and reproductive restraint do not go well, it is not because the idea is new or unacceptable, but rather because our promotional efforts are weak, sporadic, and poorly conceived. Success, as always, is directly proportional to the amount of hard work, good sense, and money that go into the project.

I would like to discuss briefly several key words that identify relevant aspects of family planning communication. These are: commitment, resources, organization, professionalization, campaigns, coverage, and evaluation. Any one could be the subject of an entire paper.

Commitment

Last Wednesday's Heard Tribune carried in a two-paragraph, front-page story a reminder of the magnitude of the task we are engaged in. "Every minute. . .235 babies are born in the world and 96 persons die, for a net population increase of 139 a minute, 8,309 an hour, 199,450 a day, and 72.6 million a year." Our task—the population control job that we call family planning—is to reduce that last number to zero. Fortunately, we don't have to do it all this year or next, but if we want to get it done at all, we have to work at it seriously from now on. The nature of population growth is such that, even if, starting tomorrow, we were able by some miracle to reduce every couple's reproduction to two, the population would continue to grow for another generation or two.

Our present technology is adequate for the job, but our present commitment is far from adequate. There are now some 600 million reproducing couples in the world; millions of new ones are added each year, and millions of old ones move out of the reproductive age span. Somehow these 600 million and the new ones coming along each year have to be reached, informed, and induced to limit their reproduction. Government leaders must be concerned about the problem and must accept the fact that reducing fertility is an important government responsibility. Obviously this is a formidable task that will require great effort and resources. But the commitment that would make such effort possible does not yet exist. No country puts any substantial proportion of its national income into family planning, and of the amounts budgeted for family planning, relatively small portions are allocated to communications. Almost anywhere one goes in the developed and developing world he is told that population growth is the world's—and in many instances, the nation's—most serious problem. But the effort that such a belief would seem to call for is not being made.

Despite the impressive activity during the past decade of governments getting involved in family planning, it is probably true that the number of people who are aware of the problem and concerned about doing something on an appropriate scale to cope with it is proportionately small—in the governments who are promoting family planning, among the public at large, and even

among those who are working in family planning. In this conference, concerned with communications for family planning, we have heard a fair number of people say they are not concerned with population growth, but only with the health of mothers and children or with the right of married couples to have the number of children they want and only when they want them. These are very important goals, but achieving them will not solve our population problem. For that we need to promote not only the right of couples to have children but also the responsibility of couples to exercise that right in a way that takes account of the collective welfare as well as their own desires.

In the bluntest statement of what I believe the situation to be: we are not coping with the population problem because as a group we really don't want to. If, in any country, a substantial minority of the government decisionmakers or the general public believed population growth to be a real and imminent danger, we would be using communications technology to mobilize opinion and action to a much greater extent that we are now.

Resources

In communications as in other activities results are usually proportional to input. A small effort gets a small payoff; a large effort of equal quality should get proportionately more. Businesses that do not advertise tend to remain the same size or go out of business. Many that do advertise tend to prosper and grow. Family planning is not a business—although the manufacture and sale of contraceptives is, but family planning has an idea as well as some products to sell. How well the ideas and products move depends on how well they are known; and that, in turn, depends on how well they are promoted through communication channels.

Most family planning programs—national and private alike—tend to allocate only a small proportion of their budget to communications. Recently, I proposed 20 to 25 percent of the total family planning budget as a reasonable amount for communications. Many feel that this is too much; the consensus seemed to be that 5 percent was a more likely figure. India, in its present five-year plan, proposes to spend about 4 percent of its family planning budget on communications; Pakistan, I believe, was considering about 2 percent in the plan just now being adopted. Dr. Zahedi, of the Iranian Ministry of Health, told us that Iran devotes around 70 percent to training and communications, and perhaps a substantial amount of this goes for communications. Ghana is budgeting 35 percent, which should enable Ghana's family planning workers to

effectively get the message of contraception and small families to the people. Our own population office in the Ford Foundation has, over the past eight or nine years, spent more than twenty-five times as much for reproductive biology research, seeking a better contraceptive, than we have in support of communications programs to encourage better awareness and acceptance of the contraceptives we already have.

I think that one reason for the relatively meager support for communications in many programs is that they tend to be dominated by medical people whose training, experience, and interests are in personal contact communication and the one-to-one approach of the clinic and who, as a group, do not fully appreciate and are not comfortable with mass media approaches. Medicine does not advertise, nor does public health usually. The latter certainly relies on a communications approach, but the methods used are generally those involving some kind of direct person-to-person interaction. If family planning is defined as a health or medical matter—as it so often is, an approach through the indirect media tends to be viewed as unnecessary or inappropriate. Thus the budget for communications remains small and the major part of it is spent on materials and activities (for example, monthly salaries and training) that require direct contact.

There is probably no correct proportion of the budget that should be expended in every country on communications for family planning. Each country will want to work out its own allocation. But there is a noticeable tendency to underestimate both the importance and the costs of communications, which probably indicates that those responsible for communications programs should be more aggressive in presenting and documenting their claims for support.

Organization

Any family planning communications program, whether staffed by a single man with a part-time secretary, or by a group of professional specialists with a highly rationalized division of labor, will have its own place in the administrative structure of the larger organization. There is probably no single type of relationship that would be best in all circumstances, but I think communications are likely to go better if the staff of the communications unit is part of a single organization responsible for the total range of family planning functions, and if the director of communications is directly responsible to the head of the family planning program.

Each family planning program is unique in its organization and in the way that communications fit into the organizational structure. Sometimes communications are fairly prominent; in other situations they are given a relatively obscure position. Usually, the position of the communications function indicates something of the importance that is attached to communications in that program.

Professionalization

Communication is a professional function, and it ought to be performed by persons trained and experienced in one or another branch of the field. No one would think of having untrained persons perform the medical functions of family planning; however, we don't think training and experience are nearly so important in the communications part of the program. On the personal contact aspect of communications we do better—with programs frequently headed by or including trained health educators and with nearly everyone in the service and field staff having had some exposure to training in how to interview, how to present materials, and how to deal with the public. But most of these people are professionally or subprofessionally trained for something else, and family planning communications is often only an added job. It has occurred to some of us that the skills of a first-rate sales manager would be a valuable addition to the training component that prepares people for face-to-face communications in family planning. Such a man lives entirely by his ability to train others to explain a product and to persuade people to buy it. If he is not successful, he doesn't last in the job. Not all sales methods would be useful or desirable in family planning, but it is possible that some of them might be and that family planning field workers could learn a great deal from a competent sales-manager type.

On the mass media side, experienced professionals are exceedingly rare in family planning. We have not yet begun to tap the enormous amount of knowledge and creative talent that is available in advertising agencies, film studios, radio and TV stations, and journalism. I think that, once again, our conference provides an illustration. We are professors, doctors, health educators, administrators, social scientists—but where are the editors, copy and script writers, artists, layout specialists, filmmakers? If we can exclude the professors, I think we may have only one person here who is a full-time, professionally trained communications man who is working in family planning. A similar situation would be to

hold a conference on the treatment of infertility and invite only one practicing obstetrician.

Family planning communications, especially in the mass media, should be an activity with its own area of responsibility that it pursues relatively independently of the service branch. It has a big job to do in informing 600 or more million people of the dangers of rapid population growth, of both the advantages and necessities of smaller families, and in developing the climate of knowledge and opinion necessary to the wide adoption of effective contraceptive practice and the small family norm. This is not a job that can ever be done on a one-to-one contact basis. The target of the communications program is not a series of individual couples, but a set of communities and societies whose values and norms largely determine what their members believe and do. Aside from a courageous few, people do or don't practice family planning largely because of what their leaders and peers think or believe about it—or what they think their peers and leaders believe. We know from empirical evidence that mass communications techniques, competently employed, can be a powerful influence for initiating, stimulating, and supporting social change. Obviously, these techniques cannot do the job by themselves—but they never have to. The ideas they transmit, the behaviors they suggest, the values they present become the subject matter of the vast informal network of communication channels that exist everywhere. We need to get more population and family planning content into those channels so that people everywhere can have information and ideas to chew over with each other, can become aware of what population growth and high individual fertility means to them and their children, and can together move toward consensus and decision. To do this job properly and rapidly we need to mobilize and use the talents of the most creative, imaginative, energetic, and experienced communications professionals that we can find.

Campaigns

One of the words that has been relatively neglected here is "campaigns." This is strange because information and communications people generally operate through campaigns when they want to win support and approval for a product, or an idea, or even a person, as in a political campaign.

The notion of campaigns seems to me to be a fairly good way to organize and to put some sense of order into the many activities that family planning communications undertake. The various stra-

tegies and activities outlined in the solutions to the simulation exercises on Arcadia and Valhalla and those we all dreamed up in our attempts to develop communications plans for those countries seemed to need some organizing concepts to tie them together and to indicate how they are related to each other. Yet, I am not certain I can properly define what a campaign is in a way that will please the professors. It is a set of interrelated communication activities directed toward a common end or ends, that continues through time. A campaign, as Dr. Schramm told me last week, has a beginning and an end, and since these do not usually happen at the same time, there is a middle between them. What seems to me to be important about the notion from a family planning point of view is that a campaign uses a variety of approaches and that it continues for a predetermined period of time—long enough to make a difference to some public at whom the communications are aimed.

For example, the Ghana program is being organized around six interrelated campaigns, of which each is intended to do some part of the family planning communications job in a country that is just starting a national program, and all of which seem, at this early stage at least, to constitute a fairly complete communications package. They don't all start or end together, but they do overlap. All of the relevant population groups in the country should be reached by one or more of the campaigns, and the activities will include both mass media and personal contact communications.

The campaigns that the Ghanaians will undertake include:

An awareness campaign whose purpose will be to promote the recognition and awareness of just three things: the concept or words for family planning in the various languages of the country; the idea that family planning stands for something good; and the relation of the national symbol—the red triangle—to family planning.

A legitimation campaign to spread the knowledge that family planning is supported by the government and is approved and advocated by respected and prestigious people at both local and national levels.

A population information campaign, directed largely at the educated elite, to provide knowledge about the population problem: population trends in Ghana and elsewhere; the relation of population growth to development goals; and activities and accomplishments of the national family planning program.

A contraceptive information campaign to provide potential users with knowledge about the safety, effectiveness, costs, availability, side effects, and manner of use of various contraceptive methods.

A motivation campaign to promote readiness to use contraceptives along with acceptance of the values of spacing and the benefits of small families.

A reassurance campaign to allay fears and to assure users that it is safe, effective, and right to continue to use contraceptives.

What this range of campaigns indicates is the importance of several kinds of communication activity that have nothing to do with getting people to come for contraceptive service, but that are nonetheless useful in supporting or even helping to initiate a national family planning program. We have heard that Madagascar is pro-natalist and that no vigorous program is at present possible. But I should think that even there a population information campaign featuring demographic information from that island and the rest of the world would be acceptable and would be useful in helping to start appropriate members of the elite to thinking about population and its importance for development.

Coverage

If campaigns are undertaken and if they are intended to be effective, they should be intensive enough and last long enough to have some chance of making an impact on the target publics. An occasional population article in the newspaper is not likely to stir up much lasting interest or provide much knowledge. A varied series of such articles over a period of time is much more likely to do both; a series will do even better if it is reinforced by similar information coming from other sources.

About six years ago when I first came to New York City, population and family planning material rarely appeared in the newspapers or on TV and radio. Two stories a month were about all that appeared, and these only when there was some newsworthy event to provoke them. Gradually this coverage has expanded—largely because of the availability of more news and because the editors and broadcasters themselves are becoming aware of the fact that family planning and population are of general interest. Now there is scarcely a day on which there are not one or more newspaper articles—including a good many features and editorials, and almost every week there are a number of TV and radio programs in which population and family planning are featured. There

are even cartoons beginning to appear in fair numbers, and jokes about family planning circulate widely. (What happens to a lady who takes both the pill and LSD? She takes a trip without the kids.) Everyone knows about the pill—and recently especially its drawbacks, and population has become a reasonably popular topic of conversation. Despite all this, there remains a fairly large amount of ignorance about both the population problem and the nature, use, and availability of contraceptives. It takes a great deal of exposure over a long period of time to get an idea into the heads and muscles of people.

Perhaps the concept of critical mass as used in physics has some parallel here. Until there is a sufficient amount of information "in the air" and a sufficient number of people aware and interested enough to talk about it, it is necessary to keep the information flowing if any lasting changes are to be achieved.

Intense and lasting coverage through sustained campaigns is perhaps also needed in these times because of the competition for attention created by the many dramatic events that are happening in the world and that are constantly being presented to us through news media. Every day a fresh catastrophe or a new crisis distracts us. If family planning messages are to be heard and heeded in all the noise we are exposed to, they have to come through loud and clear and often.

I believe that most family planning communications programs have not tried for nor have they achieved extensive coverage, and their efforts have seldom been intensive or sustained for long periods of time. This may be one aspect that requires improvement (and will get it) in the future.

Evaluation

Although elaborate complicated evaluation procedures are probably not indicated in the case of family planning communications—although there is a fair body of opinion to the contrary, certainly some evaluative effort is likely to be indicated for every program. Surely all messages, in the media in which they are used, should be pre-tested with numbers of specific audiences before time and money are invested in large or long campaigns. Messages, along with the designs and the colors that are used in connection with them, can sometimes mean something far different from what was intended and sometimes nothing at all; therefore, they need to be rather carefully assessed before being widely used. Evaluation can be made much easier if proper attention has been

paid to making objectives explicit, since measurements can be made in terms of the specific objectives of the communications program. The effects of specific communications and of campaigns on knowledge and belief can be checked with relatively simple survey procedures. If a given family planning program has an evaluation unit, the assessment of the effects of communications programs could be a proper function of that unit. Where there is no unit, quick evaluations can generally be obtained through contact with market research and other types of organizations that maintain survey staffs and are more experienced in conducting evaluations of this type than the communications program people are likely to be. One very useful type of assessment is one that relates costs of a given campaign or message exposure to the changes it is assumed to have brought about.

One caution about evaluation has to do with the appropriateness of expectations of what a communications program can do. It would be inappropriate, for example, to expect that a single informational message or campaign could bring about a change of behavior in any substantial number of people. The influences of communications programs are likely to be relatively small in terms of behavior change and relatively large in terms of providing awareness and information. But there is a great deal of variability in communications influences, depending on such factors as the appropriateness of the media, the nature of the message and its suitability for the intended audience, the frequency and duration of the exposure, and perhaps other factors related to the timing of the exposure. How much evaluation should be undertaken, what kinds, and by whom, are matters, obviously, for a great deal of discussion.

EPIDEMIOLOGIC, SOCIOLOGIC, AND THEOLOGIC ASPECTS OF MUSLIM FERTILITY

ABDEL RAHIM OMRAN

A sizable proportion of the world's population is Muslim, for although there is no accurate enumeration of the Muslim population, a conservative estimate is 600 million. This population is found mainly in Africa, the Middle East, Asia, and portions of Europe. At least thirty-eight countries have a predominantly Muslim population of 51 to 98 percent, and several others have a substantial Muslim element, as shown in Figure 1. The great majority of Muslims reside in areas characterized by an alarmingly high rate of natural increase due to extremely high fertility and declining mortality. It is estimated that if these conditions persist, the world Muslim population will exceed one billion within three decades.

In attempting to explain high rates of population growth among Muslims, many writers tend to stress theological rather than socio-epidemiological determinants of high Muslim fertility. For example, in a recent paper read at an international conference, it was declared that " . . . Islam has been a more effective barrier to the diffusion of family planning than Catholicism."[1] This statement reveals a lack of understanding of the actual and potential role of Islam in influencing fertility. Islamic tradition can be bifurcated into a pronatalist emphasis and an emphasis on sanctions of family planning in accordance with the demands of national and individual welfare.

It is hoped that in the course of this conference, some practical means will be developed to incorporate Islamic teachings into

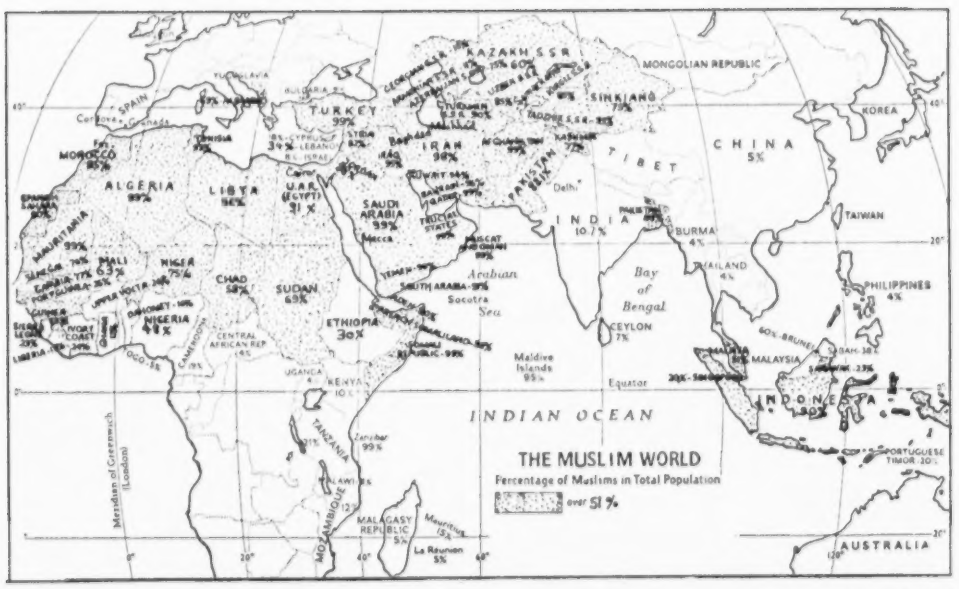


FIGURE 1 The Old World by Percent Muslim in Each Country (Modified and updated from a 1967 map of the National Geographic Society)

motivational systems and action programs for family planning. In order to provide background for practical discussion, this paper has a twofold purpose: (1) to examine religious identification as a possible fertility determinant and to clarify the mechanisms through which Islam may influence the fertility of Muslim believers; and (2) to dispel misconceptions which typify Islam as an exclusively pronatalist religion and to affirm positive aspects of Islamic doctrine which can lend theological support to the family planning philosophy. To facilitate the presentation of this complex subject, the discussion will be divided into four propositions.

Proposition 1

High Muslim fertility is a function more of sociological and epidemiological determinants than of theological doctrine.

Epidemiologic analyses indicate that the association between religion and fertility level is neither constant nor necessarily causal. The analyses used as illustrations are of four types: (a) a

synopsis of socioeconomic and demographic indices in Muslim countries; (b) a comparison of fertility behavior between Muslim and non-Muslim populations of equivalent levels of economic development; (c) examinations of fertility differentials among religious groups in the same country; and (d) a study of divergent fertility patterns in Catholic countries.

It is a common socio-epidemiologic contention that high fertility levels in transitional societies correlate negatively with standards of living and stage of economic development and positively with levels of infant and childhood mortality. An examination of a number of demographic, social, and epidemiologic indices in Muslim countries, shown in Table 1,bears out this contention. Furthermore, in comparing the fertility level and rate of population growth in Muslim countries with other countries, one finds that numerous populations of comparable economic levels reveal similarly high fertility. Figure 2 shows that several of these populations are in the same location on the correlation matrix for per capita gross national product and rate of natural increase. A similar comparison of the correlation between the birth rate and the infant mortality rate is given in Figure 3 for Muslim countries and others with comparable economic levels.

With scattered exceptions, the comparisons between Muslim and non-Muslim population characteristics are not strictly valid. Cross-cultural comparisons suffer from ecologic fallacies because the national figure represents a weighted average of multiple population subgroups whose fertility levels may differ significantly. Not only are there differences in population structure to be considered, but there also exist real differences in community size and values, degree of religious identification, socioeconomic and modernization levels, nationalistic and political aspirations. A better comparison can be made between Muslims and non-Muslims within the same geographic confines.

In a recent study in Lebanon, Yaukey[2] collected data on the differential fertility of Muslims and Christians in both urban and rural areas. The fertility of non-urban Muslims and Christians was high: 7.65 live births among the Muslims and 7.18 among the Christians. Among the Muslims the difference in fertility between city and non-city women was quite small: 1.12 live births per woman. In sharp contrast, Christian women in the city had fertility only about 52 percent as high as their non-city counterparts—a difference of 3.48 live births. When the study was controlled for education, the following results were obtained:

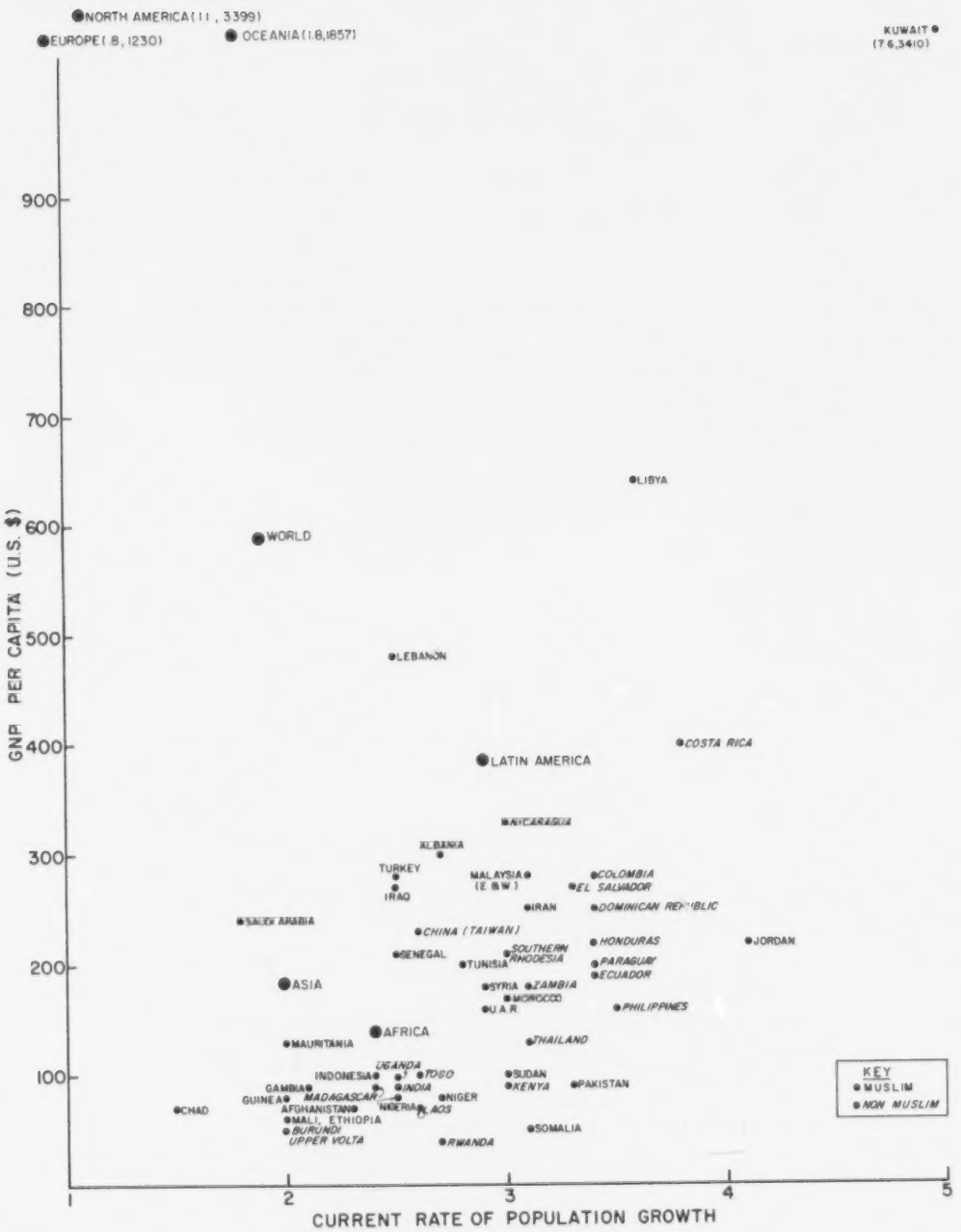


FIGURE 2 Correlation Between Current Rate of Population Growth and GNP Per Capita

Table 1. Some Demographic, Social and Epidemiologic Indices for Muslim Countries

Country	Population 1950 Millions	Population 1960 Millions	Population Mid-1969 Millions	Percent Muslim	Death Rate /1000 Pop.	Birth Rate /1000 Pop.	Infant Mortality Rate	Life Expectancy (yrs)	Rate of Population Growth	Years to Double Population	Population under 15 (%)	Per Capita GNP US-$	Per Capita National Income	Population Illiterate 15 yrs. and over (%)	Inhabitants Per Physician
Morocco	9.0	11.6	15.0	95	15-19	46	149	50-55	3.0	23	46	170	174	80-90	9,400
Algeria	8.8	10.8	13.3	99	11-14	44	86	-	2.9	24	47	220	195	75-85	5,800
Libya	-	1.3	1.9	96	-	-	-	-	3.6	19	44	640	636	80-87	5,800
Tunisia	3.5	4.2	4.8	97	17	45	110	-	2.8	25	41	200	179	75-85	10,000
U.A.R.	20.4	25.8	32.5	91	15	43	120	50-55	2.9	24	43	160	130	75-80	2,600
Spanish Sahara	-	-	-	80	-	-	-	-	-	-	-	-	-	-	630
Mauritania	.5	1.0	1.1	99	25-28	45	187	40-45	2.0	35	-	130	106	90-97	31,000
Senegal	2.1	3.1	3.9	76	17	43	93	35-45	2.5	28	42	210	149	90-95	33,000
Mali	3.4	4.1	4.9	63	30-32	52	123	30-35	2.0	35	49	60	55	85-95	77,000
Niger	2.2	2.9	3.7	75	25-27	52	200	35-40	2.7	26	46	80	78	95-99	77,000
Tchad	2.2	3.1	3.5	58	31	45	160	30-35	1.5	47	46	70	60	75-82	61,000
Sudan	-	11.6	15.2	69	18-22	52	-	-	3.0	23	47	100	90	80-88	31,000
Ethiopia	-	20.7	24.4	30	-	-	-	-	2.0	35	-	60	42	90-95	117,000
Somali Republic	1.9	2.0	2.8	99	-	-	-	-	3.1	23	-	50	45	90-95	30,000
French Somaliland	.06	.08	-	93	-	-	-	-	-	-	-	-	-	-	7,000
Gambia	.3	.3	.4	77	19	39	-	-	2.1	33	38	90	75	90-95	19,000
Guinea	2.3	3.0	3.9	65	35	55	216	25-35	2.0	35	44	80	60	80-90	27,000
Nigeria	24.3	34.3	53.7	48	25	50	-	-	2.5	28	43	80	63	80-88	33,000
Zanzibar	.3	.3	-	99	-	-	-	-	-	-	-	-	-	-	7,100
Turkey	21.0	27.8	34.4	99	18	46	161	50-60	2.5	28	44	280	244	60-65	2,800
Syria	3.2	4.6	6.0	82	-	-	-	-	2.9	24	46	180	156	65-70	4,900
Lebanon	1.3	2.1	2.6	34	-	-	-	-	2.5	28	-	480	335	40-50	1,100
Jordan	1.3	1.7	2.3	88	16	47	-	-	4.1	17	46	220	179	60-70	3,400
Saudia Arabia	-	-	7.2	99	-	-	-	-	1.8	39	-	240	165	85-95	13,000
Trucial States	-	-	-	99	-	-	-	-	-	-	-	-	-	-	-

Muscat and Oman	.6	.6	-	99	-	-	-	-	-	-	-	-	-	-	-
Yemen	-	5.0	5.0	99	-	-	-	-	-	-	-	90	75	90-95	-
South Arabia	-	-	1.3	91	-	-	-	-	-	-	-	-	-	-	2,300
Aden	.1	.2	-	80	8	37	80	-	2.2	32	-	-	-	-	33,000
Iraq	5.3	6.9	8.9	95	-	48	-	-	2.5	28	45	270	193	75-85	5,300
Kuwait	-	.3	0.6	94.6	6	52	37	-	7.6	37	38	3410	3184	50-55	920
Bahrain	.1	.2	-	95	-	-	-	-	-	-	-	-	-	-	2,200
Qatar	.02	.05	-	99	-	-	-	-	-	-	-	-	-	-	-
Iran	16.3	20.6	27.9	98	20	50	-	-	3.1	23	46	250	211	75-85	3,800
Azerbaijan S. S. R.	-	-	-	75	-	-	-	-	-	-	-	-	-	-	-
Kazakh S. S. R.	-	-	-	60	-	-	-	-	-	-	-	-	-	-	-
Turkmen S. S. R.	-	-	-	90	-	-	-	-	-	-	-	-	-	-	-
Uzbek S. S. R.	-	-	-	85	-	-	-	-	-	-	-	-	-	-	-
Kirgiz S. S. R.	-	-	-	85	-	-	-	-	-	-	-	-	-	-	-
Afghanistan	12.0	14.3	16.5	99	-	-	-	-	2.3	31	-	70	70	85-95	35,00
Pakistan	75.0	92.7	131.6	88.1	19	52	142	45	3.3	21	45	90	89	75-85	9,300 East 7,600 West
India	358.3	408.1	536.9	10.7	18	43	139	45	2.5	28	41	90	86	70-75	1,800
Kashmir	-	-	-	77	-	-	-	-	-	-	-	-	-	-	-
Tadzhik S. S. R.	-	-	-	95	-	-	-	-	-	-	-	-	-	-	-
Sinkiang	-	-	-	75	-	-	-	-	-	-	-	-	-	-	-
China (Mainland)	546.8	650.0	740.3	15	11	34	-	-	1.4	50	-	-	80	40-50	-
(Taiwan)	7.6	10.6	13.8	-	6	29	20	65-70	2.6	24	44	230	185	35-45	1,500
Malaysia	-	-	10.7	51	7	36	49	57-65	3.1	23	-	280	250	70-80	6,400
East Sabah	.3	.5	-	-	-	-	-	-	-	-	-	-	-	-	-
East Sarawak	.6	.8	-	-	-	-	-	-	-	-	-	-	-	-	-
West Malaysia	5.2	6.9	-	-	-	-	-	-	-	-	-	-	-	-	-
Indonesia	76.0	92.6	115.4	90	21	43	125	-	2.4	29	42	-	85	55-60	-
Albania	1.2	1.6	2.1	69	8.6	34.0	86.8	65	2.7	26	-	300	315	20-30	1,800

Sources: Demographic Yearbooks, 1950-1967 (New York: Statistical Office of the United Nations)
World Data Sheet (Washington, D. C.: Population Reference Bureau, 1969)

FIGURE 3 Correlation Between Birth Rate and Infant Mortality Rate

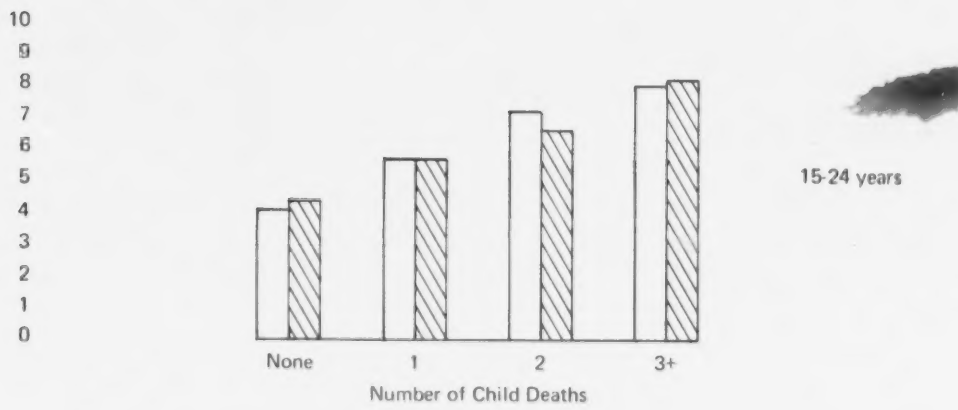
	Fertility	
	Muslim	*Christian*
Rural uneducated	*High*	*High*
Urban uneducated	*High*	*Low*
Urban educated	*Moderate*	*Low*

The author explains that Lebanese Christians in urban areas are a relatively wealthy and strong minority who have been exposed to Western influences more than their Muslim counterparts; hence their fertility follows a pattern identified as typically Western.

Too often, studies that give evidence of high fertility fail to control for social and economic factors which may significantly affect fertility, even when they are conducted on Muslims and non-Muslims in the same geographic area. El-Badry[3] made a statistical analysis of 50 percent of the births registered in Bombay in 1960 and found that Muslim fertility in the city was exceeded only by Buddhist fertility. In a concurrent analysis of census data, he found that certain indices of low standards of living were also highly correlated with high fertility. However, these indices were not available separately for each religious group, therefore, it could not be shown whether high Muslim fertility was related more to religion or to socioeconomic determinants.

A survey conducted by Hassan[4] in Cairo among Muslim and Christian women, on the other hand, showed that fertility levels correlated with the experience of childhood mortality in each group. The study population, a stratified sample of married women under fifty years of age who had been living with their husbands for at least five years, was interviewed by social workers. The interview findings on the childhood mortality experience the women had had were compared with fertility levels; the observed higher fertility of Muslim women was found to be associated more with prior experience of childhood mortality than with religion, and when the experience of childhood mortality was controlled for, the difference between Muslim and Christian fertility became insignificant. This conclusion held after controlling for duration of marriage, age at marriage, and education of the mother and father. Figure 4 shows that after controlling for childhood mortality experience and other factors, Muslim and Christian fertility are very close. The author concluded from the data that there was no justification for concern over the alleged influence of religion in perpetuating high fertility among Muslims in Egypt.

Illustrations can be drawn from non-Muslim as well as Muslim experiences; one useful example is Catholicism, since that religion



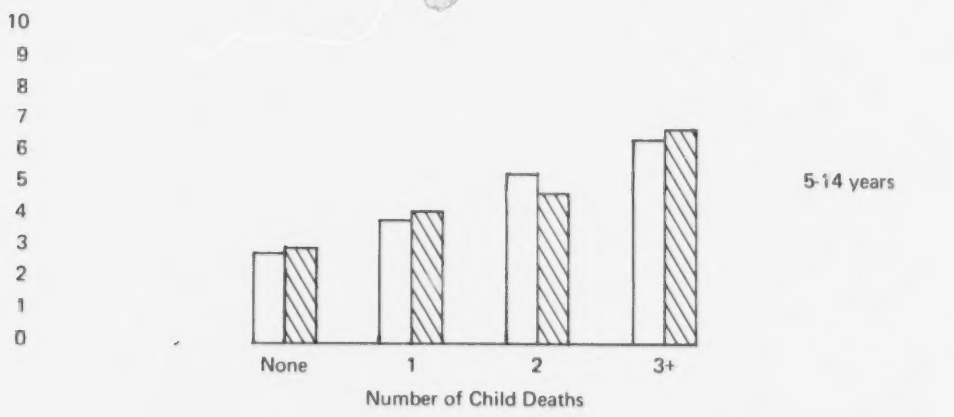
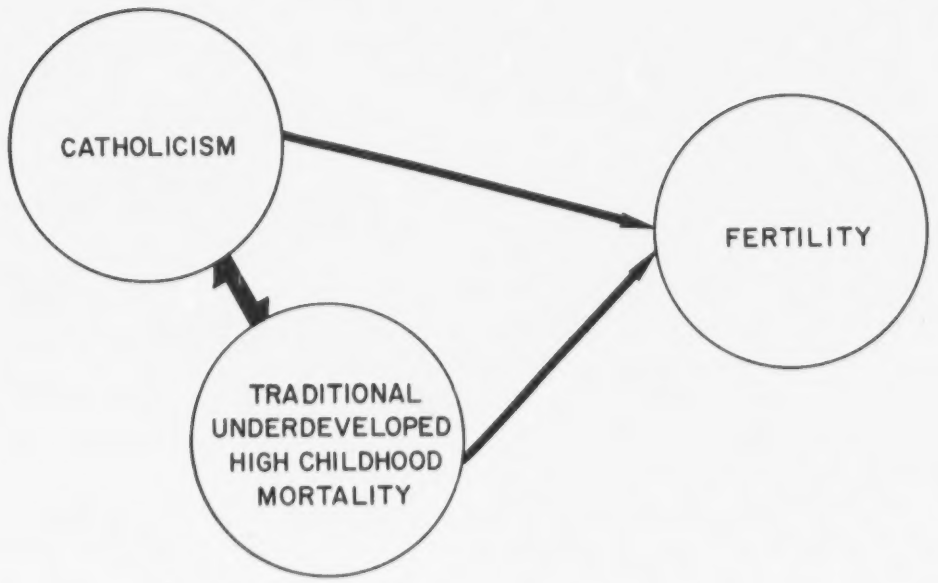


FIGURE 4 Average Number of Children Ever Born Per Mother (Standardized for Education) by Duration of Marriage, Religion, and Number of Child Deaths (Based on Table 4 in Shafick Hassan, "Religion Versus Child Mortality." See note 4.)

LATIN AMERICAN MODEL WITH HIGH FERTILITY



EUROPEAN MODEL WITH LOW FERTILITY

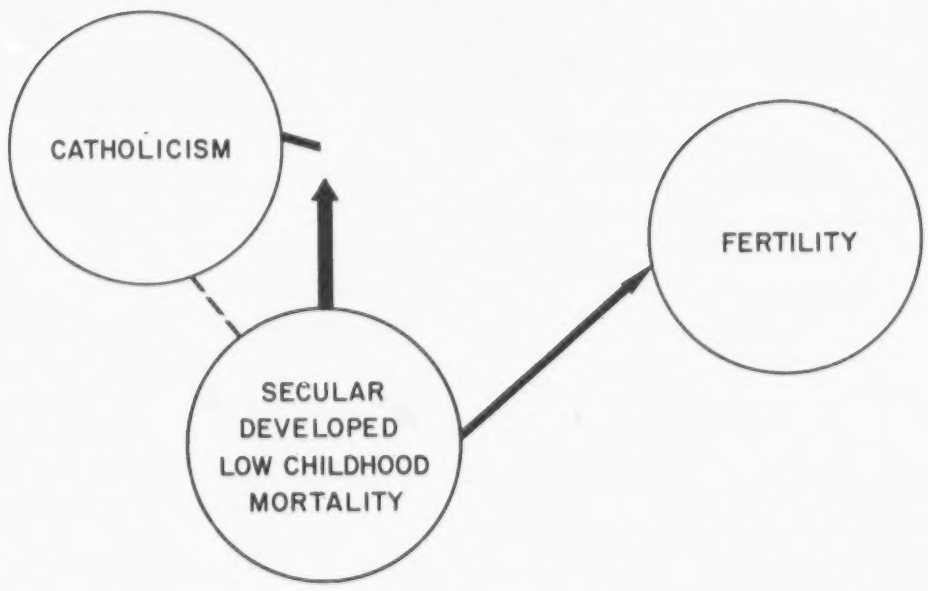


FIGURE 5 Two Models of Catholic Fertility

is dominant in both "developed" and "underdeveloped" countries. Two distinct patterns of fertility behavior are discernible in Roman Catholicism: European Catholic countries have had low or declining fertility levels for generations, whereas the Latin American countries have much higher levels of fertility. Their levels are, in fact, comparable to those of African and Asian countries. In European Catholic countries the birth rate in 1969 ranged between 16.9 per thousand in France and 21.1 per thousand in Ireland, while in Latin American nations it ranged from 21.0 per thousand in Uruguay to 49 per thousand in Honduras.[5] Since the Roman Catholic church is categorically opposed to all artificial methods of birth control, the intra-Catholic differential in fertility must be more socioculturally than theologically determined. The two divergent models of Catholic fertility are schematically represented in Figure 5. Rising levels of social and economic development and the degree of modernization and secularization have generated conflicts with traditional values, including large family norms. In the face of these changes, the direct association between religion and fertility level has virtually disappeared in European Catholic countries, and it is not unreasonable to assume that a similar transformation may occur in Muslim countries.

Proposition 2

Pronatalism in Islam is real but is neither absolute nor representative of the comprehensive attitude of Islam toward family formation and planning.

Islam's pragmatic approach to life is reflected in its sacred texts. At the same time that universal marriage was encouraged—"marry and increase your children," the inspired writings also spoke of the quality of life in terms that have been interpreted as being in consonance with family planning philosophy; even in the face of adverse environmental conditions, high death rates, and high value placed upon children, pronatalist values were never absolute. However, it is a fact that Muslim women spend most of their reproductive years in conjugal union and that at any one time from 70 to 86 percent of the women between fifteen and fifty-four years of age are married. Without the use of contraception, fertility under these conditions will continue to soar. Fortunately, the thrust of tradition has not overshadowed a genuine concern for the quality of life.

1. Islam has always opposed equating power with sheer numbers or letting quantity take precedence over quality. In war,

numbers did not ensure victory against all adversity; even here Muslims were admonished to be mindful of the quality of the faithful. Muhammed cautioned his people to be prudent lest they fall prey to aggressive nations. The companions queried, "Will that be because of our small numbers?" He replied, "No, in fact you would then be plentiful, but you would be weak like scum, washed away by the flood."

2. According to Fagley,[6] encouragement of the faithful to "marry and increase" is much less common in the Qur'an than in the Torah, and certainly no more frequent than in the Bible.

3. Although polygamy is not unique to Islam, it is frequently invoked in an effort to explain Muslim fertility patterns. In fact, polygamy pre-dated Islam and in many cultures served an important function in the social system. Islam, however, was the first religion to try to abolish polygamy in much the same way that it sought to abolish slavery. It ordained specific conditions for the equal treatment of all wives, admitting at the same time that this was a near impossibility. Thus, a number of Muslim scholars argue that the Qur'anic text of this regulation in effect prohibits polygamy. In any case, studies have proved that the demographic contribution of polygamy to excessive fertility is negligible.[7] Only 3 percent of Muslim marriages are polygamous, and women in polygamous unions have fewer children than women in monogamous marriages. Polygamy is therefore a more spectacular feature of Muslim institutions than a decisive factor in Muslim natality.[8] Because it has outlived its social function, a number of Muslim countries have legislated against polygamy, while numerous others are in the process of enacting restrictions.

4. There are, in addition, some explicit statements of the hardships that can arise from an excessive number of children. Says the Prophet, "The worst hardship is to possess plenty of children with inadequate means"; and Ibn-Abbas, one of the companions said, "Having plenty of children is one of the two poverties, while a small number of children is one of the two prosperities." Amr Ibn-el-Aass warned the people of Egypt against four practices that would lead to disastrous endings, one of which was having too many children. These statements were made at a time when there were many sociological and epidemiological reasons for sustaining high fertility. Thus, it may be concluded that Islam has consistently advocated a planned family under a variety of circumstances. Needless to say, when a limited number of children is desired, the means to control family size must be sanctioned.

5. Recognizing the health hazards of excessive fertility, Islam provides for the protection of mothers, fathers, and children through promulgation of the doctrine of "no harm." In effect, a family should not incur health or financial hardship for lack of knowledge and means to limit family size. The Qur'an states: "A mother should not be made to suffer because of her child, nor should he to whom the child is born (be made to suffer) because of his child" (II-233).

Recent epidemiologic literature gives scientific support to this basic concern for health proclaimed fourteen centuries ago. Studies in various countries have documented that large family size can have deleterious effects on the health of individual family members.[9] A partial list of the undesirable side-effects often associated with large families include high fetal wastage, high infant mortality from communicable diseases and malnutrition; high frequency of diabetes and gynecological disorders in the mother and decreased maternal efficiency; retarded growth and development and subnormal intelligence of children.

To conclude this proposition, it can be said that Islamic pragmatism and a realistic approach to life have ensured its preservation and influence. On the one hand, it advocates a pronatalist theme in the face of pandemics, wars, and excessive mortality of children; and on the other it prescribes a planned, well-provided-for family as the basic unit of Muslim society. These two themes of Islamic law are depicted in Figure 6. Which of the two themes is invoked and the size of the Islamic family are determined by epidemiological and socioeconomic influences, both at the family and national levels.

Proposition 3

Methods of birth control are sanctioned by all fundamental sources of Islamic law, and in recent years many Muslim countries have adopted family planning policies in agreement with these sanctions.

There are four fundamental sources of Islamic law. The first is the *Qur'an;* the second is the tradition of the Prophet including his statements known as *Hadith,* his deeds, and his tacit approval. The third source is the consensus of the *Ulema* or learned theologians, and the fourth is *al-qiyas*, or jurisprudence by analogy.

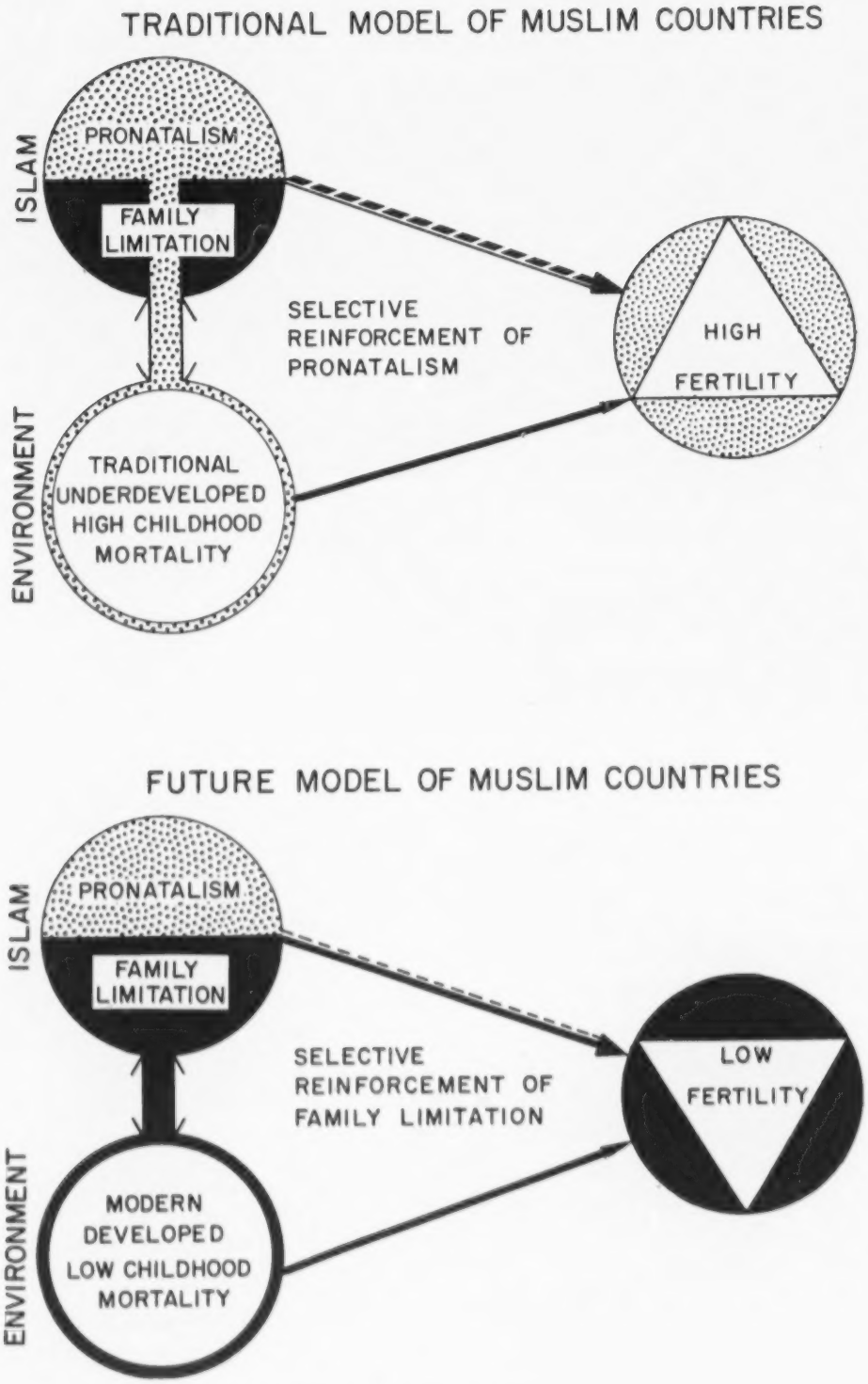


FIGURE 6 Islam and Planned Parenthood

The Qur'an: There is no verse in the Qur'an which categorically prohibits al-azl or other birth control measures. On the contrary, there are verses that encourage planned families. The central doctrine of "no harm" to the parents from having a child has previously been explained. The Qur'an also endorses the practice of lactation: "The mothers shall give suck to their offspring for two whole years if they desire to complete term" (II-233). This implies a minimal spacing period of thirty-three months between children: nine months for pregnancy and twenty-four for lactation. During this period, the chance of pregnancy is reduced by the physiologic effects of lactation and by abstinence or other birth control methods.

The method of birth control in use in the early days of Islam was al-azl (*coitus interruptus*). A number of the companions agreed that al-azl was in fact a sort of minor "waad" or killing of a fetus. This was negated by the Qur'an, however, for the fetus is not considered a creature of God until it has passed through the successive stages of development. Says the Qur'an:

> We placed him as seed in a safe lodging, firmly affixed; then we made the seed into a clot of congealed blood; then of the clot we made a (foetus) lump; then we made out of that lump bones and clothed the bones with flesh; then we *developed* out of it *another creature*. So blessed is God the best to create (XXIII-12, 13, 14).

The Tradition of the Prophet reveals that al-azl was practiced "during the time of the Prophet when the Qur'an was being revealed." If al-azl was not permissible, either the Qur'an or the Prophet would have forbidden it at that time. The only qualification made by the Prophet was that the permission of the wife must be sought.

The Consensus of the Ulema (theologians): There is a consensus of the Ulemas that al-azl can be practiced by Muslims, although some of them qualify indulgence in the practice. Among the Sunnis, the imams of the Shafei, Hanafy, Maliky, and Hanbaly mathhabs (groups of jurisprudence) universally sanction the practice, with the majority requiring prior consent by the wife. Likewise, the Sheite imams have accepted this method of birth regulation, if approval of the wife is secured at the time the marriage is contracted.

Al-qiyas (or jurisprudence by analogy): This is a fundamental technique of Islamic law whereby innovative practices can be sanctioned or prohibited on the basis of analogy to similar practices during the early days of Islam. Several centuries ago,

Dāwūd al-Anṭākī, *Tadhkira* (Cairo 1281, vol. iii, p. 295)

Dāwūd al-Anṭākī, *Tadhkira* (Cairo 1281, vol. iii, p. 294)

FIGURE 7 Excerpts from Persian and Arabic Medical Texts (From Norman Himes, *Medical History of Contraception*. See note 10.)

many of the imams sanctioned methods other than al-azl for birth control. The Hanafy imams, for example, declared that: "It is permissible for the wife (preferably with the approval of the husband) to occlude the mouth of the uterus so that the semen cannot reach it with the purpose of preventing birth." This edict was reiterated by the Grand Mufti of Egypt in 1937, at which time the IUDs, pills, and other modern methods of contraception were unknown. By invoking the principle of analogy, all methods of birth control that are medically sound and would result in no harm to the mother or child, can be sanctioned by Islam.

It is interesting to note that Muslim medical texts that were in use in medical schools throughout the world during the sixteenth century, included a number of treatises on various methods of birth control, most of which are chemical. Among these texts[10] are the celebrated *Canon* of Ibn Sina (c. 1000), *Irshad* by Ibn

Ibn Sīnā, *Qānūn* (Būlāq edition) (Vol. ii, p. 579)

'Ali ibn 'Abbās, *Kitāb al-Maliki* (Vol. ii, p. 440)

Ibn al-Jami', *Irshād* (Cairo MS., second copy, modern)

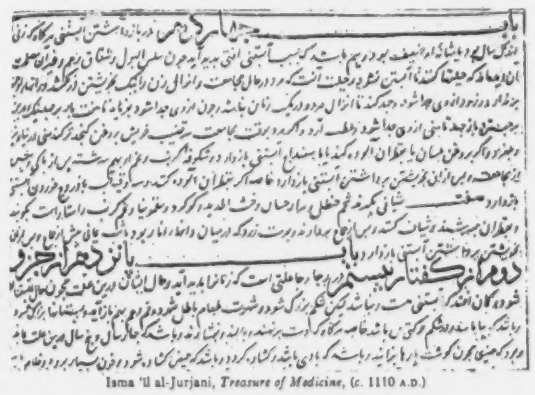

Isma 'il al-Jurjani, *Treasure of Medicine*, (c. 1110 A.D.)

FIGURE 7B Excerpts from Persian and Arabic Medical Texts

al-Jami (c. 1175), *Treasure of Medicine* by Isma-il al-Jurjani (c. 1110), *Kitab al-Maliki* by Ali ibn-Abbas (c. 990), and *Tadhkira* by Dawud al-Antaki (1281). Excerpts from these Arabic texts are given in Figure 7.

The indications for birth control as set by the twelfth century theologian al-Ghazzali[11] still hold today:

1. To protect one's prosperity, that is, for economic and social reasons

2. To preserve the health and beauty of the wife, that is, for health reasons

3. To allay anxieties over numerous children, that is, for reasons of health and marital adjustment.

To these, the twentieth century theologian al-Sharabassy[12] adds that birth control may be practiced if either or both partners have a disease which can be transmitted to the child, that is, for eugenic reasons.

It is unfortunate that these early liberal attitudes of Islam have been almost forgotten for centuries; nevertheless, there is a growing revival of these attitudes in Muslim countries currently experiencing population pressures. A number of Muslim Muftis and leaders have issued fatwas sanctioning the use of modern birth control measures.[13] The earliest is the fatwa issued in 1937 by Sheikh Abdel Majid Selim, the Grand Mufti of Egypt. Other fatwas followed, including those by the Fatwa Committee at al-Azhar University in the U.A.R. (1953); Chief Kathi of Singapore (1955); Mufti of Tregganu, Malaysia; the Advisory Council on Religious Affairs in Turkey (1960); Mufti of Iran (1964); the Grand Mufti of Jordan (1964); and Assistant Mufti of Malaysia (1965). Also of interest is the "Statement on Population by World Leaders" which gives high priority to family planning in their national programs. Of the twelve leaders signing the document, six were heads of Muslim states. The following is an excerpt from the complete text:

> We believe that the great majority of parents desire to have the knowledge and the means to plan their families; that the opportunity to decide the number and spacing of children is a basic human right.[14]

There are numerous KAP (knowledge, attitudes, and practice) studies[15] in Muslim communities which lend support to this statement by indicating that a highly favorable attitude prevails among Muslims toward family planning. The majority of Muslim couples have limited knowledge of the possibility of preventing pregnancy, and few of them have any knowledge of modern methods of birth control. Some two-thirds of all couples express great interest in learning how to control fertility and space their children, and many say they would do so if they had the appropriate means. In almost all Muslim countries, couples expect governmental family planning programs.

Fortunately a majority of Islamic nations have elected to sponsor national family planning programs or to sanction and support local and voluntary programs. The status of family planning in various countries is given in Table 2. Egypt, with one of the most critical population problems, incorporated family planning into the 1962 national charter, saying that the problem of the population increase

> . . . constitutes the most dangerous obstacle that faces the Egyptian people in their drive towards raising the standard of production in their country in an effective way.
> While the attempts at family planning, with the aim of facing the problem of the increasing population, deserve the most

Table 2 *Government Position on Family Planning Programs and Policies*

Country	Policy and program	Support but no policy	No support, no policy
Algeria	. .	. .	X
Cameroon	. .	. .	X
Dahomey	. .	X	. .
Ethiopia	. .	. .	X
Gambia	. .	X	. .
Ghana	X	. .	. .
Kenya	X	. .	. .
Madagascar	. .	. .	X
Mauritius	X	. .	. .
Morocco	X	. .	. .
Nigeria	. .	X	. .
Senegal	. .	. .	X
Sudan	. .	. .	X
Tanzania	X	. .	. .
Tunisia	X	. .	. .
Uganda	. .	. .	X
U.A.R.	X	. .	. .
Burma	. .	. .	X
Ceylon	X	. .	. .
Cyprus	. .	. .	X
India	X	. .	. .
Indonesia	X	. .	. .
Iran	X	. .	. .
Iraq	. .	. .	X
Jordan	. .	. .	X
Kuwait	. .	. .	X
Lebanon	. .	. .	X
Malaysia	X	. .	. .
Pakistan	X	. .	. .
Philippines	. .	X	. .
Saudia Arabia	. .	. .	X
Syria	. .	. .	X
Thailand	. .	X	. .
Turkey	X	. .	. .
Yemen	. .	. .	X

Source: Dorothy Nortman. (1969) "Population and Family Planning Programs: A Factbook," *Reports on Population/Family Planning* (December), pp. 1-48.

> sincere efforts supported by modern scientific methods, the need for the most rapid and efficient drive towards the increase of production necessitates that this problem should be taken into consideration in the process of production . . .

Proposition 4

The means to achieve significant and rapid fertility control in Muslim countries remain elusive despite growing family planning efforts; hence, more aggressive approaches are needed to effect a breakthrough. Based on the experience of other developing nations, if family planning programs fail to alleviate the population crisis, then provisions must be made to deal with the anticipated danger of induced abortion.

The efforts undertaken thus far in Muslim countries are commendable, but the task ahead is most formidable due to the unprecedentedly high rate of population increase which can continue to impede economic and social development. Failure to mitigate the population crisis through family planning programs could result in a marked increase in the frequency of induced abortion, as has been the case in other countries. Japan was determined to accelerate its transition from high to low fertility as part of its efforts to achieve economic prosperity after the severe setback of World War II. Between 1947 and 1957, a phenomenal decline of 50 percent in the birth rate was registered, from 35 to 17 per 1,000 population. According to Koya,[16] 80 percent of this dramatic decline in fertility was due to abortion and 20 percent to contraception. The number of induced abortions reported, mounted steadily from 246,199 in 1949 to over the one million mark in 1953 and rose thereafter through 1961, then dropped slightly.

In predominantly Catholic Latin America, despite the prohibition of the Church, the practice of induced abortion has been rampant. In Chile, for instance, the abortion ratio rose from 84 per 1,000 live births in 1937 to 204 per 1,000 live births in 1964. Chilean epidemiologists estimate that one-fourth of pregnancies in Chile end in induced abortion. Since abortion is illegal in Chile, women with unwanted pregnancies frequently provoke abortion by primitive means or at best with quasi-medical assistance. Plaza and Briones[17] calculated that abortion in Chile was responsible for 8.1 percent of all hospital admissions, 35 percent of emergency

surgical operations, and 27 percent of the total blood volume used in transfusion in emergency departments. They also estimated that in 1960, 57,368 cases of abortion required 184,000 bed-days and an expenditure well in excess of one million U.S. dollars.

These cases are presented in an attempt to discredit the pretension that religion can effectively interdict followers from resorting to such drastic measures as abortion to ameliorate problems associated with high fertility. Actually, recent studies in Muslim countries indicate that the practice of induced abortion is already gaining momentum. A perusal of the records of any maternity ward will expose the fact that these wards are overcrowded as a result of induced abortions attempted in unsanitary conditions and without medical supervision. The following results from a Turkish survey are pertinent: there is a rapid increase in the incidence of illegal abortion; it is estimated that one-third, or 500,000 pregnancies, terminate in non-medical abortions each year; the female death rate is disproportionately high as a result; this situation creates a burden for the hospitals and medical facilities which can be translated into a major monetary expenditure.[18]

Although large numbers of abortions may be almost inevitable—as indicated by the cases described above, their number and severity could be lessened and an epidemic forestalled by comprenensive birth control campaigns. To convey the magnitude of the effort required, we shall cite the Egyptian experience as an example. If the trends exhibited by crude birth and death rates in the period 1950 to 1965 continue through the decade of the seventies, the population of Egypt may reach forty-six million by 1980, with an average annual growth rate of 3 percent between 1971 and 1980. The mathematical model in Figure 8 reveals that an astoundingly large target population, represented by the *Y* axis, must be reached with highly effective contraception to lower the rate of population growth. The same change in the growth rate could be accomplished by abortion without contraception as shown on the *X* axis. It is improbable that either solution will be realized independently of the other, but when the motivation to reduce fertility is high, some combination of contraceptive effectiveness and incidence of abortion is likely to result.[19]

Conclusions and Recommendations

In conclusion, we can emphatically say that the time for implementing family planning programs is now. The first steps in this monumental task have been taken in many areas, but much more

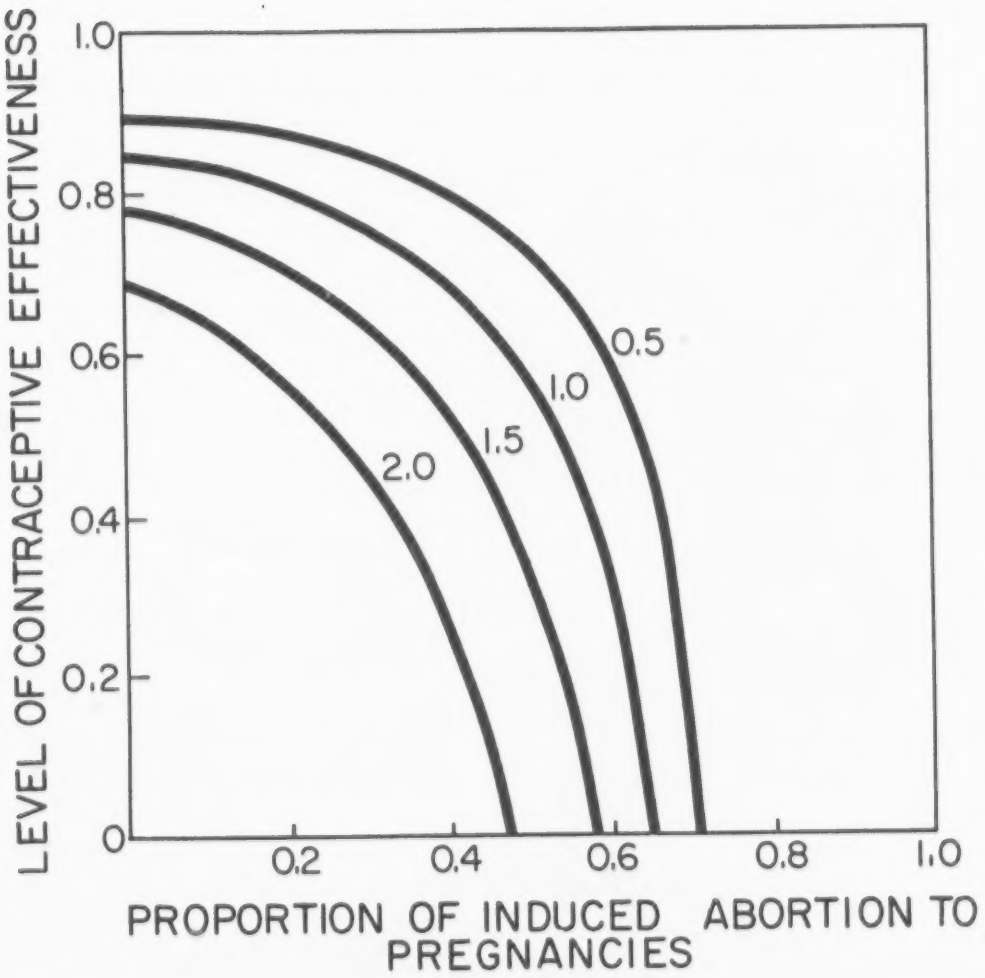


FIGURE 8 Relation Between the Proportion of Induced Abortions to Pregnancies and Level of Contraceptive Effectiveness Required to Achieve Rates of Growth of 2, 1.5, or .5 Percent in Egypt by 1980, Assuming High Fertility and Low Mortality (From A. R. Omran and Nader Fergany, "Can Egypt Accomplish Her Demographic Transition Without Abortion?" See note 19.)

intensive work is needed. It is the responsibility of religious as well as political and scientific leaders to promote an awareness of the crisis facing our world. We can no longer afford to think in parochial terms, for the family of man is outgrowing its natural habitat. Once sensitized to the urgency of the situation, each nation must face the challenge of waging a successful campaign to extend the knowledge of family planning in the ways most appropriate and effective within its own cultural and political context. No one country's program will be replicated anywhere else although some basic concepts are generally accepted. Developing nations are at an advantageous crossroads in this respect, for much can be learned from the experience of "developed" nations–in terms both of effective action and of mistakes to be avoided.

In Muslim countries, one of the greatest assets for the advancement of family planning is to be found in the flexibility of Islam itself. From the evidence presented in the sampling of studies considered in this paper, it can be seen that traditions of religion are an integral part of the fabric of life, often reinforcing patterns which have been socially or epidemiologically determined. Yet, Islam formally exerts great influence over the faithful and can be used as a potent force for change in combination with or as inspiration for political, economic, and medical means. Whereas responsible pronatalism was once an important factor in the religion, now that environmental, community, and individual constraints necessitate family limitation, Islam can provide positive sanctions for the use of all medically sound methods. In this the roles of the Mufti and imam are of paramount importance as leaders in community opinion. Furthermore, the structure of Islam facilitates the transmission of small family norms, since family life education and religious training are customarily combined.

An adequate treatment of the possible approaches to curbing Muslim fertility are beyond the scope of this paper, but the following two recommendations merit consideration:

1. Since Islamic teachings pervade the social, economic, and political life in Muslim countries, full use must be made of the religious network for the propagation of family planning ideas and methods. Religious leaders must act more responsibly and aggressively to bring fertility behavior into closer accord with national goals and professed religious ideals. This may require intensive specialized workshops designed for religious personnel sponsored by the education and communication units of family planning programs.

2. Religious as well as medical leaders can be instrumental in building a sense of personal involvement and commitment into family planning programs. Through the implementation of the health theme in motivational systems, encouraging child-spacing, and dissemination of small family norms, responsible leaders will be accepting the challenge to improve the quality of life for all. Education and communication units should incorporate, among other things, an active campaign to enlist the effective participation of the medical profession for the purpose of integrating family planning advice as a part of medical practice in every specialty.

NOTES

1. Dudley Kirk, "Factors Affecting Muslim Natality," in Bernard Berelson *et al.* (ed.), *Family Planning and Population Programs* (Chicago: University of Chicago Press, 1966), pp. 561-79.
2. David Yaukey, *Fertility Differences in a Modernizing Country* (Princeton: Princeton University Press, 1961).
3. M. A. El-Badry, "A Study of Differential Fertility in Bombay," *Demography*, 4 (1967), 626-40.
4. Shafick Hassan, "Religion Versus Child Mortality as a Cause of Differential Fertility." A paper presented to the Population Council of America Annual Meeting in Cincinnati, Ohio, April 1967.
5. *1969 World Population Data Sheet* (Washington, D.C.: Information Service, Population Reference Bureau, April 1969).
6. Richard M. Fagley, "Doctrines and Attitudes in Regard to Fertility," in Olivia Schieffelin (ed.), *Muslim Attitudes toward Family Planning* (New York: The Population Council, 1967), p. 42.
7. H. V. Muhsam, "Fertility of Polygamous Marriages," *Population Studies* (London), 10 (July 1956).
8. Kirk, "Factors Affecting Muslim Natality," p. 573.
9. Abdel R. Omran, "The Health Theme in Family Planning with Emphasis on the Relation Between Family Size and Family Health" (in preparation, 1971).
10. Norman E. Himes, *Medical History of Contraception* (New York: Gamut Press, 1963), pp. 135-69.
11. "Islamic Opinions on Contraception: Translation of Extract from Al-Ghazzali and Ibn Kaiyim," *Journal of the East Pakistan Academy for Village Development*, 1 (August 1960), 3-8.
12. A. E. Sharabassy, *Religion and Family Planning* (in Arabic), (Cairo: Public Relations Department, Ministry of Social Affairs, 1966).
13. *Muslim Attitudes toward Family Planning*, pp. 1-13.
14. *Ibid.*, pp. 15-6.
15. Selected KAP studies: Jean Morsa, "The Tunisia Survey: A Preliminary Analysis"; Bernard Berelson, "KAP Studies on Fertility"; and C. Chandrasekaran, "Recent Trends in Family Planning Research in India," all in Berelson (ed.), *Family Planning and Population Programs*. Also: "Turkey: National Survey on Population," *Studies in Family Planning*, 5 (December 1964), 1-12; and "Thailand and Taiwan: Program Effects After Eight Months," *Studies in Family Planning*, 13 (August 1966).
16. Y. Koya, "Why Induced Abortions in Japan Remain High," *Research in Family Planning*, Section 2 (1962).
17. S. Plaza and H. Briones, "El Aborto como Problema Asistencial," *Revista Medica Chilena*, 91 (April 1963), 294-7.
18. Turgot Metiner, "Turkey" in *Family Planning and Population Problems*, p. 140.
19. A. R. Omran and N. Fergany, "Can Egypt Accomplish Her Demographic Transition Without Abortion?" (in preparation).

SIMULATION EXERCISE 1

DEVELOPING AN INFORMATION AND EDUCATION PROGRAM FOR ARCADIA

SUZANNE WOLFE, ROBERT BLAKE, AND ROBERT GILLESPIE

I. Instructor's Notes

Arcadia, the country described in this exercise, is typical of many countries in the world today. It is populated by three major cultural groups, has been independent for eleven years, depends on a rural-based economy, and is plagued by all the problems of developing countries.

Arcadia does not have a population policy. Political leaders believe that any public discussion about limiting population growth rates would be politically hazardous. There is a growing realization among members of the Planning Commission, however, that continued population growth will adversely affect development progress.

The Family Planning Association of Arcadia, an affiliate of International Planned Parenthood Federation, is the only organization carrying out family planning activities in Arcadia today. These activities are without government sanction but are being officially ignored. Two part-time clinics have been operating in the capital city, Atlantus, and another part-time clinic operates in the second largest city, located in the Southern Province. Each of these clinics is staffed with a full-time Public Health Nurse, a midwife, and an outreach worker. The headquarters office is

staffed with a full-time Executive Director and a full-time Program Officer for Educational Activities.

The question we are asking ourselves (and our group) is what kind of information and education activities should the Family Planning Association of Arcadia, with its limited resources, attempt to carry out?

We are structuring our answer to this question, first, by thinking through the objectives of such an I & E program, considering the kinds of strategies we would follow to reach these objectives, identifying target audiences for information activities, listing activities to be carried out, and finally, breaking down these activities into monthly work plans for the coming year.

It is suggested that Resource Advisors clearly state the steps the group will follow and list the steps on the blackboard. This should encourage groups to move as quickly as possible through the five steps (we are allocating only three hours for the exercises).

Step One: Setting Objectives The point to emphasize here is that the Education Officer needs to set priorities very carefully. It seems clear that his first priority should be to try to influence people who, in turn, can influence government policy. When government resources become available for population work, there is hope for mounting effective programs. Therefore, if participants insist on talking about use of radio, newspapers, and the like, aimed at the general population, resource people need to point out that one man with limited resources can do very little to influence 700,000 couples (one-sixth of the total population of 4.3 million) to use birth control methods.

The second objective, ensuring that existing Family Planning Association clinics are fully utilized, is important as a demonstration that Arcadian couples *will* accept birth control services. Present clinic operations are obviously very poor as illustrated by small case loads and dropout rates. The clinics now in operation must be "model clinics," in every sense of the word: medical and educational services require much improvement.

This third objective, identification of individuals who can provide access to large numbers of potential acceptors, will provide the Family Planning Association of Arcadia with a method to recruit large numbers of family planning acceptors with a minimum of input. It is intended that work on objective three will not begin until late in the first year of operation. We have tried to point out in this exercise the need to (1) set priorities for activities and (2) achieve some limited but immediate results.

Step Two: Strategies to Accomplish Objectives During pretesting of this exercise, the authors learned that if there was a great deal of discussion on setting objectives, strategies became less clear to participants. If this occurs, the Resource Advisor may well want to list the strategies on the blackboard with a minimum of group discussion. Probably, the Resource Advisor will want to point out that each target group identified in Step Three will be influenced by different kinds of messages.

The strategy outlined in the information and education programs for Arcadia is based on the need to influence government policy through a sharply focussed campaign directed toward opinion leaders; to increase attendance in Family Planning clinics now in service; to modify fertility behavior among the easiest group first; and later, to extend education and services through individuals and agencies who can provide large numbers of potential acceptors.

Step Three: Identifying Target Groups It is suggested that Resource Advisors make clear that we are talking about two types of target groups: the first groups are those who can influence top-level policy; the second are those groups, or individuals, who can provide access to large groups of people. A few groups, such as tribal leaders in Arcadia, might be listed under both headings. Advisors might also keep in mind that presently certain groups in Arcadia may well be out of bounds; it is unlikely that much headway could be made with school teachers, the army, or government employees until some headway is made in interpreting the program to government leaders. There may be others that could be added to those mentioned in the information plan, but we need to keep in mind that government is extremely cautious and a low profile is desirable until some support is achieved. Further, advisors may want to point out that Target Group A, influencers of government policy, is the priority group to be reached in the initial stages.

Step Four: Annual Work Plan This is a partial list of activities that might be carried out by the I & E officer during the year. These activities are directed toward the respective target groups and employ the strategies listed in Step Two. Resource Advisors will attempt to obtain such a list from their groups and will, of course, encourage participation in building the list of activities. We have attempted to list these activities in terms of priority, but certainly each group might react differently to our listing. We think that most of these activities can be carried out by the Education Officer with his limited resources.

Step Five: Monthly Work Plans After the group agrees on a list of activities, advisors may wish to draw a monthly calendar on the blackboard and ask their groups, "Let's look at the first activity we've mentioned. What should the Education Officer do in July (August, September)?" Advisors should allow sufficient lead time for preparation of news releases, radio scripts, and so on. Advisors will note that later in the year we propose a number of seminars and informal meetings using Family Planning Association board members as contacts. Also, later in the year, the Family Planning Association begins activities in postpartum programs and begins working with industrial/plantation managers.

II. Description of Arcadia

1. *Area:* 48,000 square miles
2. *Population:* 4.3 million
3. *Language:* English (official), tribal dialects including a widely spoken pidgin English
4. *Religion:* 1/3 Christian, 2/3 Moslem
5. *Climate:* Hot, wet, and very humid. Rainy season—May through October. Atlantus (capital) average daily high near 85°F. year round.
6. *Major City:* Atlantus, capital, port. Population: 1.1 million
7. *Economy:* Palm kernels, cacao, coffee, ginger, and kola nuts are cash crops. Diamonds, iron ore, and chrome mined. Industry mainly palm oil processing, canning, and rice milling.
8. *Government:* Constitutional parliamentary government. Of the seventy-four seats of Parliament, sixty-two are filled by universal suffrage election, and twelve are the seats of chiefs representing the tribal councils. The term of parliament is for five years unless dissolved prior to expiration of its term. The majority of parliament's representatives are politically conservative.
9. *Geography:* Located on the eastern coast of a continent in the southern hemisphere, Arcadia has a coastal belt, averaging sixty miles in width, which is a region of dense mangrove swamps quite similar to the Florida Everglades. Stretches of wooded hill country rise from the coastal belt to the gently rolling plateaus in the north. Mountains tower to heights of 6,000 feet in the southwestern area. Although there is a nominal dry season from November to April, heavy rains, especially in July, August, and September, contribute to the dense, almost jungle-like growth characteristic of Arcadia.
10. *Currency:* Arcada (A 1 = $1.40 US)

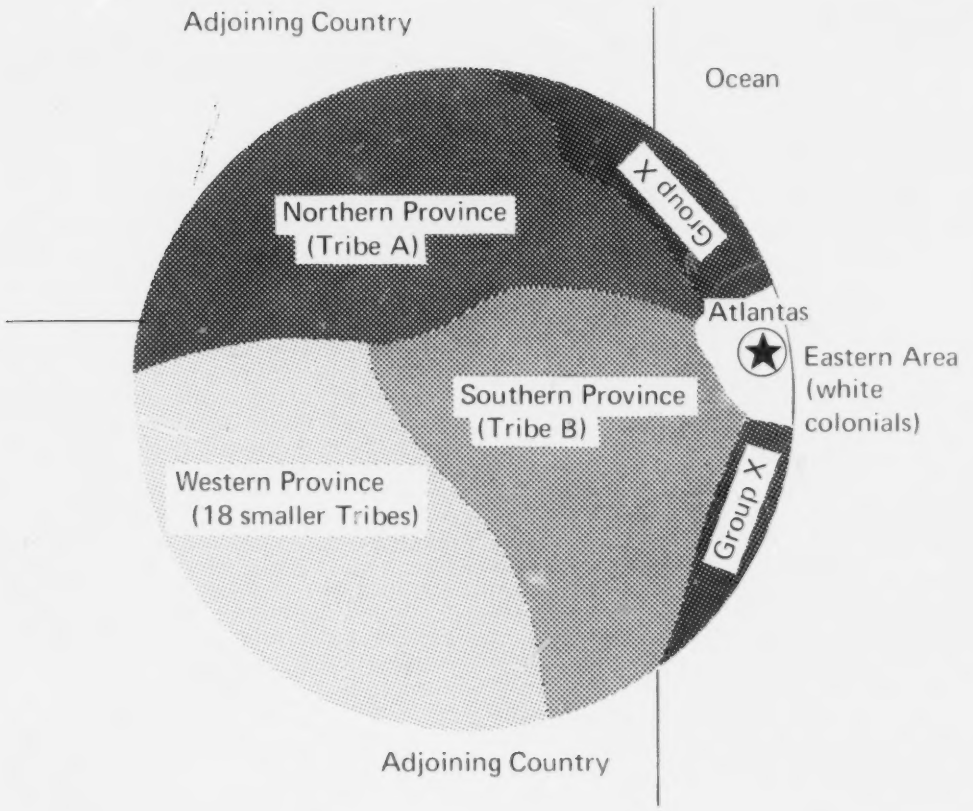


FIGURE 1 *Ethnic Population Distribution in Arcadia. Ethnic groups listed in each area indicate majority and not sole inhabitants of locale.*

BACKGROUND

Arcadia was populated by black peoples of two large Tribes (A and B) and eighteen much smaller tribes, all dating back to unknown times, when it was taken over in the late eighteenth century by a white colonial power. The colonials brought with them a black ethnic group, similar in heritage to the indigenous tribes, but they were not descendants of Arcadians. This additional ethnic group, which will be called Group X, settled in the coastal regions of Arcadia. Tribe A inhabited the Northern Province, Tribe B the Southern Province, the white colonials settled in the now largely urban Eastern Area, and the eighteen smaller tribes sparsely populated the mountainous Western Province. (See Figure 1.)

Through peaceful development and mutual agreement among the indigenous tribes, Group X and the colonials, Arcadia gained independence in 1959.

POPULATION
(DENSITY , DISTRIBUTION, MOVEMENT, AND GROWTH PATTERNS)

In 1969, the estimated total population of Arcadia was listed at 4.3 million. Nine percent of this number inhabited the Eastern Area, and 91 percent lived in the provinces. In spite of a relatively moderate rate of population growth, Arcadia has a high population density when compared with the other nations on the same continent. With the exception of the Eastern Area, which has approximately 900 persons per square mile, the population density of Arcadia is relatively even throughout, with an average of ninety persons per square mile. (See Table 1.)

Although descendants of the original white colonials still comprise a sizeable proportion of the population in the urban Eastern Area, they are by far a minority in the overall Arcadian population, totaling only 5 percent. Tribe A and Tribe B together comprise 60 percent of the total population, Group X accounts for 25 percent, while the eighteen smaller groups make up the remaining 10 percent.

Employing an urban threshold of 1,000, we find that at the time of the last census 25 percent of the total population lived in towns of more than 1,000 persons, while smaller communities in the 1,000 to 1,999 population range made up about 60 percent of the total number of urban locations.

Generally, except for the capital, which is five times larger than the next largest town, Arcadia is characterized by a great many small towns or large villages of doubtful urban character. The

TABLE 1 *Population of Arcadia*

	Population spread (%)	Persons per square mile	Percent of population indigenous to each area	English literacy (%)
Eastern Area (including capital)	9	900	50	38
Provinces as a whole	91	90	. .[a]	4.66
Northern	. .	. .	84.9	3
Southern	. .	. .	68.7	6
Western	. .	. .	64.1	5

[a]Three out of every four residents remain in province of birth.

migration level from the rural to urban areas has been about 7 percent during the last four years, but this rate will not radically or immediately alter the rural or semirural character of life.

While international migration played a significant role in the past, the last survey discovered that only 2.4 percent of the population had been born outside Arcadia.

It is not possible to compute the actual present rate of natural increase because records of births and deaths outside the Eastern Area are highly unsatisfactory. However, official estimates predict that the population will double within the next thirty-three years. The approximate crude birth and crude death rates are listed as 52 and 33 per thousand, respectively. Infant mortality is 105.

RELIGIOUS COMPOSITION

Arcadia is not a homogeneous ethnic or religious community. In 1963, Tribes A and B were the largest with 31 and 29 percent of the total population respectively. This approximate equality between the two largest ethnic groups has no parallel on the religious level: one-third of the population is Christian, and two-thirds are Muslim.

LANGUAGE DISTRIBUTION AND LITERACY

The colonials still strongly influence the languages of Arcadia. English is the official language, but pidgin English is the language spoken primarily by Group X. It is also widely spoken among all the other ethnic groups—all of whom have their own tribal languages. The pidgin English dialect is perpetuated by many folk tales and proverbs.

All the time of the 1963 census, 7.7 percent of the population ten years of age and over claimed to be able to read and write in English. (Seventy percent of these were males and 30 percent were female.) However, the likelihood of exaggeration on the part of many respondents suggests that a substantial upward bias must be considered probable in this figure.

Literacy in the languages of Tribe A and Tribe B was tabulated and about 2 percent of the population claimed a reading and writing ability in one or both of these languages.

At the provincial level, the Eastern Area had the highest rate of literacy, 38 percent; followed by the Southern Province with 6 percent; the Western Province, with 5 percent; and the Northern Province with 3 percent.

Education In 1963, 90 percent of the population over five years of age had never attended school. Although Arcadia hopes to progress to universal primary education by 1990, and the actual number of students in primary school has doubled in five years, less than 20 percent of the children in this age group are presently going to school. If infant mortality is reduced without subsequent reductions in fertility, it is estimated that even if the education program continues to expand at its present rate, the proportion of children outside the school system might increase rather than decrease over time.

NATIONAL INCOME

Since gaining independence in 1959, Arcadia has developed energetic programs to improve social, health, and economic conditions. However, while the gross national product increased from 201 to 243 million Arcadas a year during 1964-67, the per capita income increased from 78 to 87 Arcadas during the same period.

Given these conditions, an increase in the present rate of population growth would limit economic development by reducing the nation's capacity to save.

MEDICAL PERSONNEL

There are approximately 143 physicians, 170 nurses, and 310 midwives in Arcadia. It is estimated that 65 percent of these medical personnel are located in the Eastern Area and are serving only 10 percent of the population. The existing rate at which doctors are being trained will barely keep up with the present increase in population. Even with the continued training of additional paramedical personnel, it is estimated that only 25 percent of the nation's births were attended by someone with properly sanitized equipment. (Tetanus is the second most frequent cause of maternity death, and an effort is being made to have at least 75 percent of all births properly supervised to eliminate tetanus of the embilical cord.)

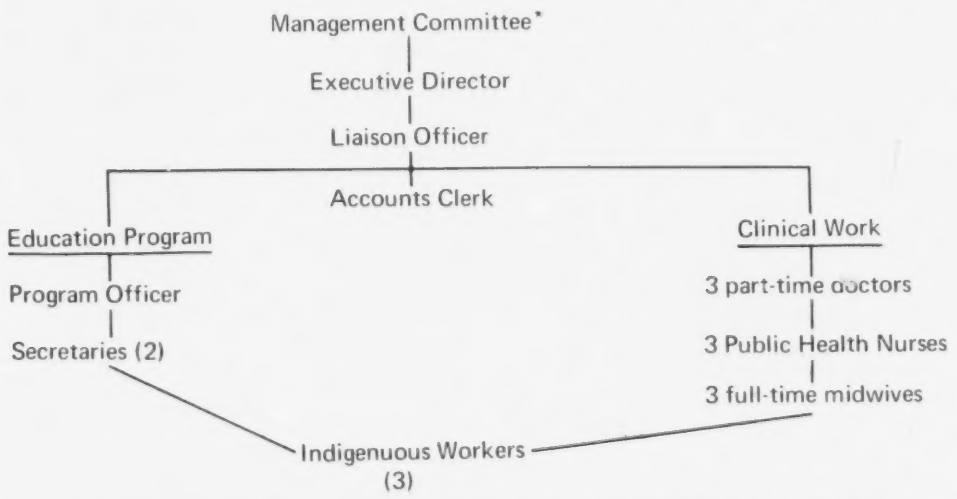
STATUS OF FAMILY PLANNING PROGRAMS

Because Arcadia has a relatively small population, most national leaders and professional groups have not considered population to be a problem. With infant mortality quite high and diseases such as malaria still present, talk about population control has seemed absurd.

At present the government maintains an official position of neutrality with regard to family planning. Most national leaders have felt that population control was a politically hazardous topic, and health officials have not even requested a budget for promoting family planning because of a lack of adequate personnel to provide the contraceptive services. (Priority has been given to preventing needless deaths from measles, small pox, tetanus, and poliomyelitis.) Some members of the planning commission, however, have expressed concern because half the population is in the unproductive age categories below fifteen years of age, and predictions are that this group will double within the next thirty-three years.

The Arcadian Family Planning Association (Figure 2), supported by modest funding from International Planned Parenthood Federation (London), has established three clinics which have been in operation for three years. Two of the clinics are located in Atlantus, and one is in the largest town in the Southern Province. Total active patient load is 273 women, all of whom take oral contraceptives. Dropout rates are about 45 percent annually.

Condoms are available through most of the pharmacies in the Eastern Area, but this information is not widely known. Family Planning Association clinics are making almost no effort to increase their patient load because they lack funds. For the same reason, no information and education programs have been started.



*The Management Committee meets semi-annually and is responsible for the overall policy of the Family Planning Association of Arcadia. The committee consists of five Arcadians: an undersecretary in the Ministry of Health, the Deputy Minister in the Ministry of Social Affairs, the Chairman of the Department of Obstetrics and Gynecology at the local University Hospital, the wife of the Minister of Labor, and the wife of a leading local industrialist.

FIGURE 2 *Family Planning Association of Arcadia Organization Chart*

TABLE 2 *Arcadia—Chart of Media*

Media	Number	Total availability	Per 100 people
Press			
Daily newspapers	2	30,100[a]	0.8 (copies)
Non-daily newspapers	6	20.600[b]	. .
Radio			
Transmitters	2	. .	0.4 (receivers)
Cinema			
35 mm cinemas	3	. .	0.05 (seats)
16 mm cinemas	1	. .	

[a]Daily circulation
[b]Combined circulation, weekly

Although many couples report wanting six or seven children, there are at least 10 percent of the women in the reproductive age groups who are having births they do not want. The illegal abortions which are performed and the number of women who subsequently end up in hospitals indicate, to a degree, the number of unwanted births that are occurring. At present, abortion cases account for about one-third of staff work-time in the hospitals with maternity wards.

With an increasing desire for more education and a better way of life, more couples, particularly in the urban areas, want information on spacing or stopping child birth. However, one survey conducted by the Arcadian University Social Science Department reported that in urban areas only 40 percent of the population knew of a contraceptive, in the rural areas less than ten percent answered positively.

If the government maintains its present position of neutrality regarding family planning services, any significant increase in services is precluded. If, however, the government endorses and financially supports family planning, substantial progress might be possible in the near future.

MEDIA

Press Two daily newspapers are published in English in the capital city of Atlantus. In addition, there are six non-dailies of general interest with a combined circulation of 30,100 and seven other periodicals with a total circulation of 20,600. (See Table 2.)

Included in this last figure is a woman's magazine which is circulated mostly to the wives of professional and national leaders.

The Government Public Relations Office in Atlantus also publishes a weekly bulletin which is distributed free of charge.

Radio The Arcadian Broadcasting Service, established as an independent department of the government, operates two shortwave transmitters. Programs are broadcast for six hours and thirty-five minutes daily. Time is broken down as follows: English—60 percent of total transmitting time; language of Tribe A—15 percent; language of Tribe B—15 percent; and pidgin English—10 percent. An additional ninety minutes a week are devoted to programs in eight other local languages. News bulletins are broadcast daily.

A redistribution system serving Atlantus and its environs is on the air some ten hours daily in English, with occasional programs in the languages of Tribes A and B.

It is estimated that the radio is listened to by half the population for at least one hour a day and is, therefore, a principal means of education.

Cinemas Some 100 feature films are imported annually, and newsreels in both 35mm and 16mm are imported weekly. Annual attendance at the commercial cinemas represents an individual attendance of 0.2 a year.

There are also twenty-five 16mm projectors, which are used for public showings in halls, schools, and community centers, and there are four 16mm mobile units. Educational films are exhibited by the Department of Information which has mobile units and maintains a film library. The Department of Information expects to have its own film-producing unit in the near future.

III. Proposed Information and Education Program for Arcadia

(July 1970–June 1971)

The objectives of Arcadia's proposed information and education program are:

1. To inform national leaders, professional groups, and other opinion leaders of the social and economic consequences of population growth.

2. To recruit family planning acceptors for existing family planning service units.

3. To identify individuals who can provide access to large numbers of potential acceptors.

STRATEGY TO ACCOMPLISH OBJECTIVES

1. Influencing opinion leaders in order to change government policy toward population growth is of the highest priority. Specific advantages of a policy to reduce population growth rates, both immediate and long-range, must eventually to be structured for specific target groups. Physicians, for example, should understand that the extremely high rates of infant mortality and abortion (infant mortality is 105 per 1,000, and abortion cases account for one-third of staff time in hospitals with maternity wards) are due to high fertility rates.

2. Although only three family planning clinics now provide services, it is essential that these clinics become "model" clinics, providing excellent medical services and operating at full capacity. Further, efforts should be undertaken to encourage middle class Arcadians to seek family planning services from their private physicians. Also, provisions should be made to subsidize non-medical contraceptives should existing clinic facilities reach capacity. Certainly, the major effort in the first few years will be to attempt to change fertility norms in urban areas, beginning with the upper and middle class couples, where some immediate success is possible.

3. Even in underdeveloped societies, there are leaders who can provide access to large numbers of people. Factory owners, labor union leaders, mine owners, large landholders are examples. These leaders can give significant impetus to family planning programs and need to be persuaded, through a planned communications effort, that family planning for their employees is socially desirable and economically beneficial.

TARGET GROUPS

1. To influence government policy:
    1. Political leaders at national and regional levels
    2. Members of the Planning Commission
    3. Professional medical organizations
    4. Professional legal organizations
    5. Mayors
    6. Newspaper editors and publishers
    7. Magazine editors and publishers
    8. Journalists
    9. Radio broadcasters
    10. Women's clubs
2. To provide access to large audiences:
    1. Tribal chiefs
    2. Religious leaders
    3. Factory managers
    4. Mine owners
    5. Major land owners
    6. Trade union leaders

ANNUAL WORK PLAN

1. Develop a mailing list of all people in target audience.
2. Send weekly news releases to all newspapers in Arcadia.
3. Organize a fifteen-minute, weekly radio program
4. Send a bi-monthly newsletter to target audience mailing list.
5. Conduct a press seminar at the University of Arcadia.
6. Prepare exhibit for annual meeting of Arcadian Medical Association.
7. Commission articles on population for leading magazines.
8. Working with wives of Family Planning Association officials, organize teas for wives of professional groups.
9. Contact students in the Sociology Department of the University and organize KAP Survey on Contraception in Arcadia.
10. Conduct a brief survey of the patients in the three family planning clinics to determine literacy rates, income bracket, tribal affiliation, level of education, and reasons for coming into clinic.
11. Develop a symbol and a slogan for the Arcadian Family Planning Program.

12. Develop and have printed two pamphlets--one on the oral contraceptive and one on reasons for family planning.

13. Design posters for Family Planning Program.

14. Organize meeting with midwives in the two cities in which there are family planning clinics.

15. Organize a postpartum contact program whereby indigenous workers contact postpartum women, present pamphlets to them, and offer an appointment at one of the clinics.

16. Write a weekly newspaper column (in addition to weekly news release) in the form of three questions and three answers. The column will attempt to answer questions concerning contraception, dispel rumors, and guide readers either to private physicians, family planning clinics, or drugstores for contraceptive methods.

17. Prepare two questionnaires to be sent to all people on mailing list to gauge their awareness of the population problem and to determine ways in which they could participate in family planning programs.

18. Organize a followup program on all clinic patients, with indigenous workers making visits two, six, and twelve weeks after clinic visits to determine if acceptor is having any difficulty with pill and to reassure her of its safety and effectiveness.

19. Working with Family Planning Association officials, plan a budget for the next year: submit one to IPPF, London, and one to the Ministry of Finance, Arcadia.

20. Evaluate clinic attendance and dropout rate for the year.

MONTHLY WORK PLAN

JULY

1. Prepare a list of names and addresses of all those included in the target audience. (See p.) Sources for the names and addresses are: Government Gazette, Who's Who, telephone directory, lists of members of professional organizations, subscription lists of leading magazines, journals, and newspapers, and the Arcadia Year Book. By the end of July, 2,500 names should be on the mailing list. By the end of August, 5,000.

2. Prepare the format for the first bi-monthly newsletter (4 pp. multilith) to be sent to target audience mailing list, and begin writing articles. Lead article for the first newsletter should be information on the rapid population growth in recent years. Other articles could be in the form of interviews with the people

most concerned with overpopulation in Arcadia (such as members of the Family Planning Association) and reports on speeches given by world leaders in population studies. Plan to send first newsletter on August 15.

3. Write a news release the last week in July and send to all newspapers (daily and non-daily) on the same topic as lead article in Newsletter #1—general facts about overpopulation, comparison with other countries, and so on.

4. Conduct a brief survey of clinic patients in order to determine literacy rates, income bracket, tribal affiliation, level of education, language, and reasons for coming to clinic. At least forty to fifty patients should be interviewed.

AUGUST

1. Prepare to send out four news releases this month to all papers. Examples of topics to be used: general information concerning the effect of overpopulation on (1) food production, (2) employment, (3) education, (4) economy.

2. Contact radio stations and arrange for a fifteen-minute program each week for the rest of the year. Program should be conducted in English, since target audience is primarily English-speaking. Radio broadcasts should attempt to coincide with topics of weekly news releases. For example, the first week, two large landholders could discuss the effect of overpopulation on food production; the second week, two factory owners the effect on industry; the third week, two teachers could deal with the effect on education; and so on. These programs could be in the form of interviews or small panel discussions.

3. Send Newsletter #1 to target audience mailing list on August 15.

4. Develop a symbol and a slogan for the Arcadian Family Planning Association clinics. To begin, prepare two or three different kinds of logos and slogans and test them in clinics; then, choose the one which appears to be most meaningful to the patients.

5. Using the data collected in the July survey, develop appropriate pamphlet on the oral contraceptive pill, reaffirming the instructions given to pill acceptors by clinic physicians and nurses.

SEPTEMBER

1. Begin to make arrangements for a two-day press seminar to be held the first week in November. Plan to invite all publishers, editors, newspaper men, broadcasters, and others con-

nected with mass media. Include division heads within the Ministry of Information. Prepare background information on population and family planning and contact Minister of Information to give opening talk. Plan to have an economist informed on population matters give the afternoon talk. The second day, plan for a panel discussion including doctors, educators, industrialists, members of the Family Planning Association, planning commissioners who are informed on population, and a high ranking person in the Ministry of Health, preferably the under-secretary. During September, make plans for the lecture hall at the university and whatever rooms will be necessary for the seminar. Invite, by letter, all persons to be included in the program.

2. Continue radio programs each week. For variation, this month's programming could consist of four short dramas, showing the problem overpopulation can cause the individual. For example, two women could discuss the problems involved in having a lot of children, or having children too close together; a woman who has experienced an unwanted pregnancy could warn a friend, who is pregnant, not to try an illegal abortion.

3. Send out four newspaper releases, one each week. Try to coordinate radio dramas with news releases, that is, each week the news release could be in the form of a feature story in interview style, with the reporter interviewing a woman who has had a lot of children too close together, or a woman who has had an illegal abortion. The persons interviewed could remain anonymous.

4. Begin collecting information and writing stories for Newsletter #2, to be sent out October 15. Lead topic this month could be directed to the medical aspects of overpopulation, for example, abortion rates, maternal and child health, infant mortality, and the like.

5. Have 2,000 pamphlets on the oral contraceptive pill printed.

6. Design posters: one which connects the Family Planning Program with the symbol; and one which directs itself to the most frequently given reason (see survey) for coming to the clinic.

OCTOBER

1. A good portion of the time in October will be spent in final preparation for the press seminar in November. Invitations will be sent out to all the people in mass media, and the program will be coordinated as speakers decline or accept. The final program should be multilithed by the end of the month, to be distributed at the beginning of the seminar.

2. At least two of the four October news releases (preferably the last two) should concern the forthcoming press seminar, stating who will speak, topics, panelists, procedure, purpose. The other two news releases might deal with religious attitudes toward birth control (interviews with a Christian religious leader and a Muslim religious leader).

3. The radio shows for this month should follow up the news stories with mention made each week of the forthcoming press seminar. The bulk of the programming, however, could deal with religious attitudes. Again, interviews with Christian and Muslim leaders, or panel discussions, could be presented on the air.

4. Sent out Newsletter#2 October 15.

5. Begin writing article for the largest women's magazine or ask a prominent Arcadian doctor to write it, pointing out maternal and child health benefits in family planning.

6. See that the first pamphlets (pill) are distributed to all pill acceptors in clinics and that copies of the pamphlet are mailed to every physician in Arcadia.

7. Have 600 posters printed.

NOVEMBER

1. First week will be spent directing press seminar, collecting papers of those who spoke, writing thank-you notes to participants as well as writing a full report. Send completed report to the Government Planning Commission, legislative leaders, and all members of the Family Planning Association.

2. News releases for November should consist of four different articles on various topics discussed at the press seminar. (Interviews with participants could be used, or excerpts from their papers used in straight reporting.)

3. The radio spots for the month should also consist of interviews with leading representatives at the seminar—preferably people connected with government, such as the Minister of Information, the under-secretary in the Ministry of Health, members of the Planning Commission.

4. Begin writing Newsletter #3 to be sent December 15. Again, use as lead articles the topics discussed most fully at the press seminar. (The report for the Planning Commission could be used as a basis.)

5. Send article to women's magazine.

6. Place posters in at least 500 locations in Atlantus and 100 locations in city where other clinic is located.

7. Begin working on Pamphlet #2: this one should be motivational—why women should plan their pregnancies. Last page of pamphlet might direct reader to one of three clinic locations.

DECEMBER

1. Prepare two questionnaires to be sent to all people on the target audience mailing list to gauge their awareness of the population problem and to determine ways in which they could participate in family planning programs.

2. News releases for the month should be concerned with overpopulation in relation to education. For example, one could be a report on the literacy rates in Arcadia, another could report on the overcrowded conditions in classrooms, the effect of poor education on industry and economy, or the long-range effects on the present educational system.

3. Radio programs for this month should follow the same themes as the news releases. For example: an interview with a student in one of the higher grades, an interview with a teacher, with a mother who is concerned about the education her children are receiving, with a professor of education from the University of Arcadia.

4. Send out Newsletter #3 December 15. Include questionnaires and return envelopes.

5. Ask a prominent doctor to write article on medical methods of contraception to be sent to the Arcadian Medical Association's *Journal.*

6. Begin developing a list of midwives in the two cities in which there are family planning clinics. If you are unable to obtain a mailing address, find a reliable means of personal contact.

JANUARY

1. Begin preparation of an exhibit for the Arcadian Medical Association Convention in late February.

2. News releases for January might deal with the effect of overpopulation on the national economy, the gross national product, per capita income, and so on.

3. Radio broadcasts should also deal with economy. Interviews or panel discussions could be held with economists, bankers, industrialists, someone from the Ministry of Finance.

4. Begin writing Newsletter #4, to be mailed February 15. Lead article this month—the effect of overpopulation on the national economy.

5. Begin evaluation of questionnaires as they return in the mail.

6. Contact wife of high official in Family Planning Association and ask her to give a tea for the wives of government leaders.

7. Distribute pamphlets #1 and #2 through a postpartum contact program. A Family Planning Association worker should give each postpartum woman a copy of the pamphlets and offer her an appointment at one of the clinics.

8. Contact all newspapers (daily and non-daily) in Arcadia and inquire about insertion of a weekly column (in addition to weekly news release) in the form of three questions and three answers each week. The questions will be letters sent by readers to the column, and the column will attempt to answer all these questions by giving information regarding the different methods of contraception, dispelling rumors, and guiding readers to either private physicians or one of the three family planning clinics.

9. Complete list of midwives in two largest cities.

FEBRUARY

1. Complete evaluation of questionnaires sent out in December and write a full report. Send copies of report to all members of the Family Planning Association, the Planning Commission, and the Ministry of Health.

2. News releases for February could deal with the health benefits of family planning and/or the health dangers involved in overpopulation; include such topics as maternal and child health, abortion, infant mortality, the two-child family compared to the six-child family, and so on.

3. Radio spots for the month should deal with the concept of family planning as a good idea: for the mother, the child, the family, the country.

4. Sent out Newsletter #4 February 15.

5. Contact wife of another official in Family Planning Association and ask her to give tea for wives of physicians in Atlantus.

6. Set up exhibit at Arcadian Medical Association Convention.

7. Ask leading economist at the university to write an article about overpopulation for the Government Gazette.

8. Begin a followup program on clinic patients. Each acceptor should be contacted by an indigenous worker two weeks after her clinic visit to determine if she is having any problems and to reassure her regarding the pill's safety and effectiveness. The public health nurse should supervise the indigenous worker and

visit any patients who seem to be having difficulty with the pill and are reluctant to return to the clinic.

9. Write weekly question-and-answer columns.

10. Continue the postpartum program.

11. Organize a meeting of midwives in one area of the city. Use list and invite them at least a week ahead. Public health nurse will be in charge of meeting, the purpose of which is to: (1) improve basic skills; (2) instill a feeling of pride in the profession; (3) instruct midwives in methods of contraception; (4) determine how midwives feel about referring patients to family planning clinics.

MARCH

1. Begin writing Newsletter #5 for mailing April 15. Lead article might be effects of overpopulation on economy and employment.

2. News releases this month might deal with medical methods of contraception. Each week a different method is discussed at length: the pill, the loop, the diaphragm, sterilization.

3. Radio spots, too, could discuss the benefits and side effects of the different methods of contraception prescribed by the doctor.

4. Contact a sociology professor at the university and inquire about the possibility of involving students in population studies in Arcadia. For example, students could be used to do a KAP Survey regarding contraception, or a study on the number of induced abortions in Arcadia each year.

5. Ask wife of another leading official in Family Planning Association to give tea for wives of business and civic leaders in Atlantus.

6. Continue weekly question-and-answer column.

7. Continue followup program on clinic patients.

8. Continue postpartum program.

9. Organize another meeting of midwives in a different part of Atlantus.

APRIL

1. News releases this month deal with non-medical or drugstore methods of contraception. The condom, foam, foam tablets, creams, and jellies could be discussed; statistics on each could be provided.

2. Radio spots should deal with the same topics as news releases—a prominent gynecologist might discuss each on the air.

3. Contact leading industrialists, factory owners, land-

holders (all those who have access to large audiences) and point out the advantages of providing family planning services as opposed to providing only maternal benefits. Determine how receptive they would be to any of the following:

a. Providing family planning services as part of their medical services to employees.

b. Providing family planning services by mobile clinics furnished by the Family Planning Association.

c. Providing non-medical contraceptives to employees either free or at subsidized rates.

4. Write weekly question-and-answer column.
5. Continue postpartum program.
6. Continue followup program on clinic patients.
7. Hold meeting for midwives in another part of Atlantas.
8. Send out Newsletter #5 on April 15.
9. Followup on university study.

MAY

1. News releases deal with ineffective methods of contraception. Each week attempt to dispel rumors regarding a different method of contraception thought by local people to be effective, but which in fact, is not: douche, withdrawal, etc.

2. Radio spots deal with same topics as news releases.

3. Begin writing Newsletter #6—lead article should discuss all activities the Family Planning Association has engaged in this year, an evaluation of the situation now, and suggestions for the program next year.

4. Collect final data from the university study.

5. Evaluate each clinic as to: dropout rate, acceptor rate. Prepare questionnaire for indigenous workers in order to determine whether or not they regard the services at the clinics as adequate and, if not, how they could best be improved.

6. Use statistics gathered by students from university, information from questionnaire sent to target audience in December, information from questionnaire given to clinic workers, results of discussion with factory owners and others regarding contraceptive depots, to put together a tentative budget for the following year. Plan to work up two separate budgets—one for IPPF, London, one for the Ministry of Finance, Arcadia.

7. Write weekly question-and-answer column.
8. Continue followup program on clinic patients.
9. Continue postpartum program.
10. Organize meeting for midwives in city with the other family planning clinic.

JUNE

1. Work with officials in Family Planning Association to finalize budgets for fiscal 1972. When completed, officials of FPA then send the respective budgets to IPPF, London, and the Ministry of Health, Arcadia.

2. News releases should report on the programs that the Family Planning Association has conducted in Arcadia during the last twelve months—the results and the plans for the future.

3. Radio programs are coordinated with news releases.

4. Send Newsletter #6 on June 15, 1971.

5. Continue weekly question-and-answer column.

6. Continue postpartum program.

7. Continue followup program on clinic patients.

SIMULATION EXERCISE 2

DEVELOPING AN INFORMATION AND EDUCATION PROGRAM FOR VALHALLA

SUZANNE WOLFE, ROBERT BLAKE, AND ROBERT GILLESPIE

I. Instructor's Notes

Valhalla, the country described in the second simulation exercise, has an announced public policy to reduce population growth rates. The government is willing to spend the necessary funds to accomplish this objective. Large numbers of potential acceptors are available through a network of urban and rural public health clinics. The family planning program has gone through the usual ministerial and jurisdictional disputes which have now been settled. The program is now in the hands of a group of professionals who are struggling with the problems of providing contraceptive services and motivating large numbers of couples to use them. Education and services for family planning are entirely governmental programs. What kind of information and education activities should be considered by the Valhalla Director of Information and Education?

We are suggesting that information and education activities be concentrated in the four largest cities in Valhalla during the first year—this is necessary, we believe, to ensure some initial successes. Further, it will provide an opportunity to test and evaluate content as well as media. We are also suggesting that the Information and Education program be directed to those groups most easily reached—to skim the cream off the market in order to develop a 'critical mass' of acceptors who will legitimize the practice of contraception. The extension of services through rural clinics is relatively simple because of the network of existing health clinics, so we also suggest that educational materials be prepared for rural

groups, that a distribution system be set up through rural clinics, and that a series of seminars be arranged for workers in rural clinics during the latter part of the first year.

The information plan also calls for continued effort in interpreting the family planning program to opinion leaders as well as initiation of work with educational leaders in planning for population education content in future public school curricula.

Steps One and Two: Setting Objectives and Strategy to Accomplish Objectives Resource Advisors may wish to emphasize the need for concentrated efforts to be directed toward those groups of couples who are most likely to become contraceptors. It would be a mistake to try and do everything at once–Information and Education activities would then be diffuse and without impact. We suggest that the Director of Information and Education gather information from a sample of acceptors and dropouts in order to provide some data on which to base his program. We further suggest that he concentrate his efforts in a few urban centers early in the year in order to test and evaluate the kinds of messages and media that work most effectively.

Step Three: Target Groups Target groups are to be indentified and priorities assigned. Your group may identify different target groups and assign different priorities from those appearing in this work plan.

Step Four: Defining the Messages We have attempted to outline the kinds of messages that would influence the target groups we have identified. The point needs to be made, it seems to us, that message content for various groups should be carefully considered in light of the needs and background of each group.

Step Five: Annual Work Plan Again, this is a list of activities by order of priority which probably should be carried out in Valhalla during the coming year. Some of these activities are described in detail because many of the participants have had little experience with Information and Education programs. Basically, we are suggesting the following: (1) learning as much as possible about the prospective audience; (2) developing and pretesting a symbol and slogan which will tie the campaign together; (3) developing a concentrated Information and Education effort in four major urban centers using all available media; (4) developing a postpartum educational program; (5) reducing drop-out rates; and (6) setting up a program to reach large groups of people.

Step Six: Monthly Work Plan Here we have simply listed Information and Education activities by month, providing lead time for development and production of various educational materials which will be necessary for the Information and Education Program.

II. Description of Valhalla

1. *Area:* 493,000 square miles
2. *Population:* 35 million
3. *Language:* Valhanese
4. *Religion:* Moslem and Christian
5. *Climate:* Hot and dry. Except along the coast, rainfall seldom exceeds two inches a year.
6. *Major City:* Verona, capital. Population: 4,220,000.
7. *Economy:* Produces cotton, wheat, corn, millet, and barley. Phosphates, coal, manganese, and iron are mined. Petroleum reserves in the Northwestern area. Bolstered by foreign aid, Valhalla is shifting from an agricultural to an industrial economy, producing consumer goods.
8. *Government:* Valhalla is a republic divided into thirty sectors, each with a governor and an executive bureau.
9. *Geography:* Located in the northwest corner of a continent in the southern hemisphere, Valhalla is primarily desert. Only 3.5 percent of the land is inhabited, and only 2.5 percent is capable of producing crops. The coast fringe receives rain about six months of the year, but elsewhere there are only light showers or no rain at all. The southeast area is mostly desert and the majority of the population lives in the northwestern area and along the coast.
10. *Currency:* Vala (1 V = $1.00 US)

POPULATION
(DENSITY, DISTRIBUTION, MOVEMENT, AND GROWTH PATTERNS)

The population of Valhalla has doubled in the last seventy years and, according to the 1969 census, is now thirty-five million. All indications are that the population will double again before the year 2000. Population density is low, only forty-five persons per square mile, but the number of persons per square mile of arable land is 3,000.

Valhalla is still primarily rural, but there has been a gradual decrease in the rural/urban ratio from 79:21 in 1917 to about

60:40 in 1966, and there are now about fourteen cities with populations greater than 100,000. (See Figure 1.) The rural/urban differential in birth and fertility rates found in some countries does not seem to obtain here.

The birth rate has leveled off during the last five years to 38/1,000. The death rate has dropped from 26/1,000 in 1952 to 14.3/1,000 in 1969, and will continue to drop for the next ten years. Life expectancy at birth for men rose from thirty-five in 1936 to fifty-one in 1960; for women it rose from forty-one to fifty-three. The result of these changes, without a comparable decrease in birth rate, is that 45 percent of the population is now in the unproductive age category below fifteen years. Since the 1952 census, this percentage has increased 10 percent.

RELIGIOUS COMPOSITION

The distribution of population by religion has remained rather constant through this century. Excluding the frontier districts,

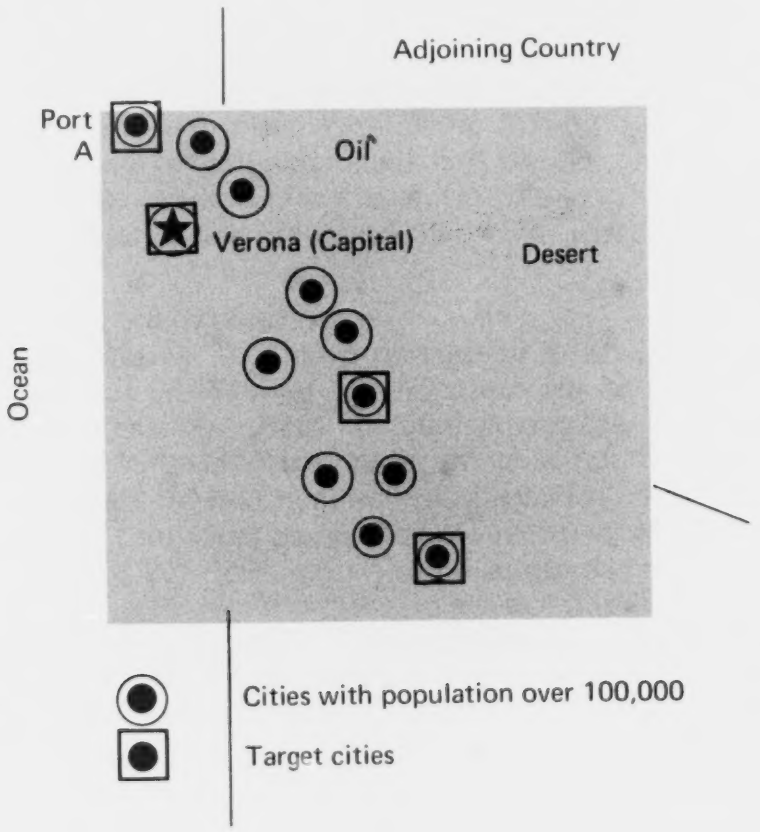


FIGURE 1 *Location of Major Cities in Valhalla*

which account for 1.1 percent of the population, the religious distribution for 1960 was 93 percent Moslem and 7 percent Christian.

LITERACY

Although the literacy rate for Valhalla is low, particularly for females, there has been a considerable rise in the past twenty years probably due to increased emphasis on education. In 1960, the literacy rate for men was 44.8 percent and for women 16.4 percent. Urban/rural comparisons are not available for 1960, but in 1957 the urban literacy rate for males was twice as great as for their rural counterparts and the rate for urban women was four times as great as for rural women.

Education Enrollment in primary and middle schools increased from 4.3 million in 1961–62 to about 7.6 million in 1968–69. Secondary enrollment increased from 170,000 to around 330,000. During the same period, the expenditures on education increased from thirty million Valhallian currency to about eighty million. Despite the increase in enrollment and the increase in expenditures, large numbers of children still remain out of school. In 1966–67, only 60 percent of the school age children were attending school. Had the population of Valhalla grown at half the rate over the previous twenty years, the facilities and personnel of 1966–67 would have been adequate for all children of school age.

SOCIOECONOMIC DEVELOPMENT

The rapid growth of population from 1917 to 1959 resulted in a sharp decline in per capita income because the economy did not develop at a comparable rate. In 1959, however, many changes took place in the economy which partly arrested this trend, and from 1959 the per capita income increased by 36 percent during the next eight years. At constant prices the annual compound rate of growth in per capita income from 1959–60 to 1964–65 was 3.9 percent.

The Valhalla Development Plans attempt to provide more secure and abundant lives for the people. But increases in agriculture, housing, classrooms, and hospital beds have kept only slightly ahead of the per capita rate of growth experienced during the last ten years. (During the last Five-Year Development Plan, the agricultural output exceeded the target of 2.5 percent per year, but the population grew at 3 percent leaving per capita food consumption at a lower level than at the beginning of the plan.)

Valhalla will need triple the current investments in research and development for improved stocks, fertilizers, insecticides, and equipment just to keep pace with the population growth.

Unemployment is also significantly affected by rapid population growth. The labor force in 1960 consisted of fifteen million people between the ages of fifteen and sixty-four. A continuation of the existing fertility rate means this age group will double before the year 1990. Since 1960, when the unemployment rate was 25 percent, there has been a reduction of only 2 percent. The problem is further complicated by the fact even though unemployment is very high, there is an insufficient supply of highly trained labor.

STATUS OF FAMILY PLANNING

Attitude of General Public Many families are having children they do not want because of inadequate knowledge regarding the stopping or spacing of childbirth. Mothers are risking their own health and that of their children by having babies too close together and having more children than they can properly care for. Many women risk having illegal abortions. Statistics show that a total of 4 percent of all certified deaths in the country are due to causes related to pregnancy. Figures from the National Hospital indicate that the incidence of abortion cases treated there may be as high as one per every three live births, and the cost of caring for illegal abortions constitutes a substantial proportion of all hospital costs.

There are indications that Valhallian women have very little knowledge of family planning, but they would like to have contraceptive services. From a national survey of women in the reproductive age groups, it was discovered that about 70 percent of the urban women and 64 percent of the rural women would be interested in learning more about family limitation. Only 4 percent of the rural women and 11 percent of the urban female population already know how to prevent births. Two-thirds of the males surveyed and three-fourths of the females said they favored the establishment of family planning services; two-thirds of both males and females indicated they would be willing to use the facilities of family planning clinics. A third of the females and nearly half the males said they believed abortion to be common in Valhalla, and about a third said they thought the populace would like sterilization as a contraceptive method. About two-thirds of the women believe abortion should be available to women who have pregnancies they do not want.

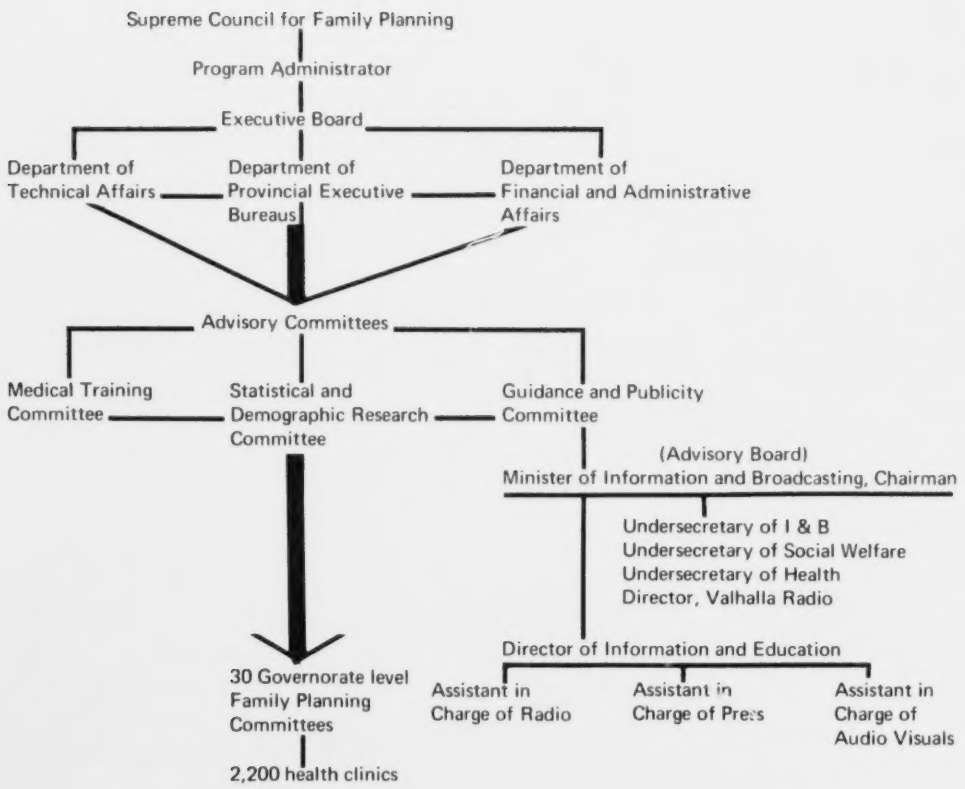

Supreme Council for Family Planning
Program Administrator
Executive Board
Department of Technical Affairs
Department of Provincial Executive Bureaus
Department of Financial and Administrative Affairs
Advisory Committees
Medical Training Committee
Statistical and Demographic Research Committee
Guidance and Publicity Committee
(Advisory Board)
Minister of Information and Broadcasting, Chairman
Undersecretary of I & B
Undersecretary of Social Welfare
Undersecretary of Health
Director, Valhalla Radio
Director of Information and Education
Assistant in Charge of Radio
Assistant in Charge of Press
Assistant in Charge of Audio Visuals
30 Governorate level Family Planning Committees
2,200 health clinics

FIGURE 2 *Family Planning Organizational Structure in Valhalla*

Attitude of Government The president of Valhalla has been making public statements about the urgency of the population crisis since 1965. Implementation of national programs, however, was not ordered until early 1968. The reasons for the delay were many:

1. There was little experience in the implementation of a program to control population.
2. In important segments of the bureaucracy, there existed an ambivalent attitude toward the need and value of birth control.
3. Jurisdictional disagreements arose between the Ministries of Health and Social Affairs as to which agency should be primarily responsible for family planning programs. Ineffective attempts were made to resolve this conflict, and the creation of numerous inter-committees gave the illusion that mediating efforts were succeeding.
4. The nation's intellectual leaders, assigned to the population problem, were ineffectual in mobilizing support for an action policy.

In 1969, however, an action-oriented group of professionals was put in charge of the population program and the government insured financial support to the program. Then, the national family planning program officially got underway. (See Figure 2.)

The plan offered contraceptive services via the country's 2,200 evenly distributed and well-staffed health clinics and centers. Staff members received extra compensation for providing these services regularly but outside the normal clinic hours. Only part of the compensation depended on patient load.

Oral contraceptives were made available to anyone who wanted them at nominal monthly prices. Within six months, more than 300 physicians were trained in procedures for inserting intrauterine contraceptive devices, and the program showed considerable promise of acceptance.

In spite of these large-scale activities, only a relatively small percentage of the women are now using the clinic facilities. Statistical evaluation is lacking, but a realistic estimate suggests that the program has managed to reach roughly 150,000 women who would otherwise not have had access to contraceptive means. This number represents an insufficient reduction in births to have any impact on the birth rate of a nation of thirty-five million.

MEDIA

Press Of a total of twenty-four morning and thirteen evening daily newspapers, all but four are published in Verona and the next three largest cities in Valhalla. In addition, there are ten weeklies which circulate in the urban and rural areas. The daily and weekly newspapers were nationalized in 1958.

It is estimated that half of all literate males (urban and rural) read at least one newspaper regularly. Relatively few women read newspapers.

Radio The state-owned Broadcasting Corporation operates thirty-five AM and five FM transmitters, and this equipment provides good reception throughout the country.

As many as 80 percent of the men listen to the radio in the cities and approximately 40 percent listen in the rural areas. Radio is the only medium which reaches women in the rural areas.

Cinema Valhalla has an active film industry; Verona has eight film studios, four of which are provided with the latest equipment. New color laboratories have been established and the quality of production has risen rapidly in the last few years.

The Information Department (Cinema Section) produces short documentary films and the General Direction of Motion Pictures,

TABLE 1 *Valhalla–Chart of Media*

Media	Number	Total availability (millions)	Per 100 people
Press			
Daily newspapers	37	1.5[a] (copies)	6
Radio			
AM transmitters	35	5.0 (receivers)	17
FM transmitters	5		
TV			
Main transmitters	10	1.0 (receivers)	3
Auxiliary transmitters	15		
Cinema			
35 mm	500		
16 mm	150	.5 (seats)	1.5

[a]Total daily circulation

under the Ministry of Culture, produces educational and cultural films. The latter organization, as do the Ministries of Education, Public Health, Social Affairs, and Labor, maintains a film library and mobile units for film shows.

Most of the cinemas are concentrated in Verona and the other three large cities in Valhalla. The country has a relatively high attendance level compared to the surrounding countries–2.8 tickets sold per capita per year. Statistics show that over three-quarters of the men go to at least one movie a year while at least 50 percent of the urban women and less than 10 percent of the rural women see motion pictures.

Television Television service, established in 1960, is government controlled. The Valhalla Broadcasting Corporation operates ten main stations and fifteen auxiliary transmitters. Approximately 75 percent of the population is within reach of these stations. Plans are underway to operate one channel exclusively for educational purposes twelve hours a day.

III. Proposed Information and Education Program for Valhalla

The objectives of Valhalla's program are to:

1. Organize an extensive Information and Education program in the four largest cities in Valhalla (Verona and three others) and evaluate its effectiveness.

2. Identify individuals and groups who can provide access to large numbers of potential acceptors and organize family planning information programs.

3. Inform rural couples of the availability of safe and effective birth control methods in their health centers with the goal of doubling the number of rural acceptors by the end of the first year.

4. Solidify support for family planning activities among opinion leaders.

5. Explore with educational leaders the possibility of including population education content in school curricula.

STRATEGY TO ACCOMPLISH OBJECTIVES

1. Information and Education programs should begin in urban, rather than in rural areas, for a number of reasons: (1) people in cities usually respond more quickly to change, and, therefore, more immediate success for the program is possible; (2) urban couples are easier to reach because communication channels are more sophisticated in cities; and (3) innovations almost always spread from urban centers to rural areas. Extensive I & E programs should be organized in four major cities during the first year in order to demonstrate the impact of a successful family planning program. These programs can be evaluated in terms of the kinds of messages that are most persuasive and the media that is most effective. During the second and third year of operation, these model programs can be expanded to encompass all major urban centers in Valhalla.

2. Leaders who can provide access to large numbers of potential acceptors (factory owners, large landholders, hospital administrators, industrialists, key people in the army and government) are important to any successful family planning program. Contraceptive services incorporated into on-going health service programs can reach a large number of people in a minimum amount of time. Additionally, these programs aid in maximizing the impact of an overall family planning program and provide a "core" group of acceptors who aid in establishing the use of birth control as an acceptable behavior.

3. Politically it is necessary to extend family planning services to rural as well as urban couples. The infrastructure for delivery of health services in Valhalla includes over 2,000 health clinics in rural areas which are already serving most of the rural people. If family planning services were upgraded and encouraged in these clinics, acceptance rates could rise quickly.

4. In order to insure continued support from opinion leaders it is necessary to inform these leaders regularly of the program's progress, plans, and goals.

5. The long-term success of a family planning program will be assured if school age children are properly educated as to effects of high fertility rates on national economy as well as on families and individuals.

TARGET GROUPS

First Priority

1. Elite and political
   - Executive and Cabinet
   - Members of Parliament
   - Senior civic servants
   - Business and industrial leaders
   - University professors and administrators

2. Provincial elites
   - Provincial commissioners
   - Provincial planning officers
   - District commissioners
   - Women's groups

3. Health community
   - Physicians
   - Nurses
   - Family planning personnel
   - Medical and paramedical personnel

4. Communications media
   - Newspaper editors
   - Radio and TV programmers

5. Religious and community leaders
   - Muslim
   - Christian

Second Priority

1. Special groups
   - Labor unions
   - Military and armed services
   - Major employers
   - Government workers
   - Municipal employees

Third Priority

1. Clients of health services
   - Woman attending health clinics
   - Men attending health clinics
   - Women attending family planning clinics
   - Husbands of women attending clinics
   - Postpartum women
   - Dropout women

2. Local leaders
   - Local authority councillors
   - Chiefs

3. Non-medical field personnel
   - Adult education officers
   - Community development workers
   - Social workers
   - Agricultural extension workers
   - Nutritionists

Fourth Priority

1. Educational leaders
   - Professional staff in Ministry of Education
   - Public school administrators
   - Leaders of Valhalla National Teachers Association
   - Leaders of PTA groups

DEFINING THE MESSAGES

Audience	*Proposed message*
Elite and political	This sophisticated audience needs to grasp fully the relationship between population growth and economic de-

	velopment, education, medical facilities, nutrition and food production, job opportunities, and general family health.
Provincial elites	The messages are the same as for the elite and political. However, the messages should be directly related to provincial and district needs.
Health community	The messages should reinforce a belief that family planning is important to family health, that family planning is a national policy, that it is an integral part of health services. Further, this audience must be kept abreast of developments in the family planning programs.
Communications media	This audience is in close contact with major sections of the general public and needs to be convinced of the importance of family planning. The messages are similar to those for the elite.
Religious and community leaders	Messages should strive to legitimize family planning by showing that contraceptive practices are compatible with religious teachings and beliefs.
Special groups	This category covers a variety of audiences. The intention here is to utilize the various organizational structures for the dissemination of family planning information. The messages should strive to create a general atmosphere of acceptance of family planning by the community and encourage individuals to adopt family planning.
Clients of health services	For women attending health clinics, the message is the advantages of

	family planning and the availability of family planning services. A similar message directed to the men should be developed. For women attending family planning clinics the message should reinforce their acceptance of family planning. A special "For Men Only" piece could be developed discussing the effect of large families on land division, school fees, food, and jobs.
Local leaders	Messages should be similar to those for special groups and should stress the benefits of family planning for family life and welfare.
Non-medical field personnel	Messages should attempt to relate the duties of field personnel to overall national family planning goals, inform the personnel of the program's progress, and provide information about human reproduction and contraceptive methods.
Educational leaders	Influencing this audience should be a long-term objective. Messages need to be much like those developed for the elite and political groups with special emphasis on the need to change family size norms among the younger generation.

ANNUAL WORK PLAN

1. Develop a separate mailing list for each of the following groups:

   Elite and political leaders
   Provincial elites
   Health community
   Communications media
   Religious and community leaders
   Labor union leaders and major employers
   Educational leaders

2. Plan Information and Education Program in four urban centers using the following steps:

a. Create a one-page questionnaire to be answered by a representative sample of acceptors and dropouts of urban family planning clinics, attempting to determine the reasons women in Valhalla are contracepting, the reasons why others are not, the prevailing fears regarding contraception, the reasons for dropouts, the values regarded most highly by the community, current levels of knowledge about contraceptive methods, and current attitudes toward family planning. Talk extensively with doctors, nurses, midwives, and other people in daily contact with family planning patients (or potential patients), gathering further information on these same topics.

b. On the basis of the information gathered in the questionnaire, develop a slogan for the Family Planning Program (such as, "Birth Control: For Couples Who Want Children . . . Later") and a symbol. Pretest.

c. Media

(1) Radio. Organize a weekly radio program and a series of five- to sixty-second spot announcements to be run on a regularly scheduled basis.

(2) Press. Prepare a weekly question-and-answer column on the topics of family planning and health to be run in all the daily newspapers in the four target cities. In addition, prepare a weekly news release and send to the same papers. Insert advertisements on a weekly basis which feature the slogan and symbol of the Family Planning Program along with the addresses and hours of local family planning clinics.

(3) Periodicals. Write or commission a monthly article on family planning to appear in the leading women's magazine.

(4) Television. Prepare at least five TV spots to be run interchangeably approximately six times a week. Endorsements by movie stars or athletes are examples. Always use the symbol and slogan of the Family Planning Program.

(5) Cinema. Develop a series of slides to be used in movie houses and special film trailers (approximately thirty seconds long) to be run between features.

(6) Indigenous Media. Prepare scripts for puppet shows, drama troops, and other indigenous media popular in Valhalla.

3. *Postpartum Program.* Organize a program in the four target cites for women who have just given birth. They are a desirable audience for a family planning program for two reasons: (1) having just had a baby, they are psychologically ready to postpone the next pregnancy; and (2) since most women in Valhalla have their babies in either hospitals or clinics, the postpartum women are easily accessible to family planning workers. Organize the program so that postpartum women in all the maternity hospitals and clinics in the four target cities of Valhalla are approached by a nurse or midwife—sometime after the birth of their babies but before they leave the hospital—and informed about the different methods of contraception and offered contraceptive services immediately, if they so desire. Filmstrips and flipbooks should be shown to groups of postpartum women while they are still in the hospital, and booklets on reasons for and methods of family planning should be distributed to the literate. Once a woman has chosen a method, she should be given a small booklet on that specific method in order to reinforce the instruction given her by the doctor. Before she leaves the hospital, each woman should be offered an appointment at the family planning clinic at the same time that she returns for her postpartum checkup. During 1970-71, this program should be organized only in the four target cities, with plans to expand services to all urban and rural areas within the next few years.

4. *Dropout Program.* Special efforts should be made to organize a program for those women who have stopped receiving services at the family planning clinics in the four target cities. Field workers should contact each woman, inquire about her reasons for dropping out of the program, provide her with appropriate booklets, and offer her another appointment at the clinic. Plans should be made to expand this program to all urban and rural clinics during the next few years.

5. *Employers of Large Groups of Potential Acceptors.* During 1970-71, an effort should be made to encourage employers of large groups of people (industrialists, large landholders, municipal employers, and the like) to incorporate contraceptive services

in their health services to employees. Newsletters should be sent out at least every other month to all such employers in Valhalla pointing out generally the benefits to a national economy involved in reduced population growth and specifically, the economic benefits each employer will experience if he incorporates family planning in his health services to employees—contraceptive services are cheaper than maternity services, for example. In the first year concentrate Information and Education program on employers in four target cities with the aim of establishing such services at the beginning of the next year in these four cities. Make plans for the expansion of the program throughout Valhalla during the next few years.

6. *Newsletters.* Multilith newsletters for each audience on mailing list and send information directed to the interests of each specific group every other month. (For message, see p. 89.)

7. *Rural Programs.* Although expansion of the family planning program to rural areas is not of first priority during this year, some initial efforts need to be made in this direction. Begin by offering the weekly question-and-answer column that appears in the papers in the four target cities to as many rural newspapers as possible throughout Valhalla. The radio programs, which have already been developed for urban areas, could be placed on rural radio stations (either as they are, or rewritten for a rural audience, if necessary). Regional Information and Education Workshops (two-day) should be held for health educators in rural areas. Invite health educators from each clinic in a five-province area (include five provinces in each workshop for a total of six separate workshops). The workshops should:

a. relate the importance of family planning activities to national goals;

b. explain the importance of information and education programs; and

c. provide specific information on methods of reaching potential acceptors, including:

(1) improvement of followup programs for acceptors and dropouts,

(2) improvement of family planning education within the health center,

(3) initiation of a postpartum program in an effort to reach all women who deliver in the clinics.

Try to hold the first of these workshops before the end of the year.

8. Organize a conference for key people in the Ministry of Education during the latter part of the year to discuss the possibility of including population education materials in school curricula.

MONTHLY WORK PLAN

JULY

(The Information and Education program for the four major cities in Valhalla will take a number of months to organize. We suggest, therefore, that all plans be made in advance and the whole program start at the same time for greater impact. Februrary 1 is the date we have chosen to begin.)

1. Develop a mailing list for the elite and political leaders and the provinicial elites. Aim for at least 600 names for the first group and 800 for the second. Possible sources for all mailing lists are: Government Gazettes, Who's Who, telephone directory, lists of members of professional organizations, subscription lists for leading magazines, journals, and newspapers, and the Valhalla Year Book.

2. Develop a one-page questionnaire as described in Annual Work Plan (p. 92) and begin having it filled out. Aim for seventy-five by the end of July.

3. Begin working on two booklets (one on reasons for family planning and one on methods of contraception, covering all methods offered by clinics in Valhalla). Be sure to use slogan and symbol of family planning program and write copy for an elementary reading level. Organize format and begin writing copy in July.

4. Begin designing two flipbooks (one on reasons for family planning and one on methods of contraception) and two filmstrips (on the same topics). Filmstrips, flipbooks, and brochures will, of course, cover much the same information, and some of the art work and copy could be shared among them.

AUGUST

1. Develop a mailing list for the Health Community. This is a very large group so aim for 2,500 names and addresses by the end of August and 2,500 more by the end of September.

2. Continue contacting appropriate people to fill out questionnaire. By the middle of August have 150 completed. Spend last half of month compiling and analyzing results.

3 Commission six articles to appear in leading women's magazine (one each month from February to June). Articles

should attempt to follow themes established for each month's radio program. For example, February–the availabilty of birth control; March–maternal and child health benefits in family planning; April–economic benefits of family planning; May–educational benefits of family planning; June–religious sanction of family planning. Contact noted authorities in each field to write articles. Arrange with women's magazine for publication of these articles.

4. Arrange for simple artwork for two brochures (reasons and methods) and have type set and final copy complete by end of month. Schedule printing for following month.

5. Flipbooks and filmstrips should progress along the same lines as the brochures. During August, complete copy for flipbook and script for filmstrip. For variation the filmstrip could convey information through a discussion between a clinic nurse and one of her patients.

SEPTEMBER

1. Continue developing mailing list for the health community. Have 5,000 names and addresses by end of September.

2. On the basis of the information gathered in the questionnaire, develop a slogan for the Family Planning Program (such as "Birth Control: For Couples Who Want Children . . . Later") and a symbol. Pre-test.

3. Contact radio stations and schedule a fifteen-minute weekly program to begin running in the four target cities the first week in February. Begin organizing the programs for February and develop four dramas around theme: availability of birth control–couples now have a choice about family size. Conversations between women, men, or couples could point out the benefits of birth control and the benefits of small families: more free time for mothers, more time to spend with each child, freedom from fear of pregnancy, benefits of spacing, the ability to plan ahead, and so on. Tape programs.

4. Write four news or feature stories to be inserted in newspapers in target cities each week in February on same theme as weekly radio programs.

5. Using the slogan and symbol developed for the Family Planning Program, design advertisements for each of the newspapers in the four target cities. Mention clinic locations and hours of family planning clinics in each area. Contact newspapers and arrange for these ads to be run on a weekly basis from February through June.

6. Deliver brochures (reasons and methods-general) to printer and have approximately 10,000 of each printed by end of month.

7. Complete pre-printing preparations for flipbooks (copy, artwork, and/or photographs) by end of month and contact printer. Begin taking pictures for filmstrip and plan to have at least one-half the pictures completed by the end of the month.

8. Send one-or two-page multilith newsletter to elite and political and provincial elite mailing lists. For content of letters, see p. 89, defining the message.

OCTOBER

1. Develop a mailing list for the communications media. Aim for at least 200 names by the end of the month.

2. Contact TV stations and notify them of your intention to place family planning advertisements six times a week beginning the first week in February. Begin working on at least five TV spots. Contact movie stars, sports figures, and others who could endorse family planning. Plan to have the slogan and symbol of the Family Planning Program at the end of each commercial.

3. Work up four radio dramas for March around the theme of better health for mothers and children with family planning. Dramas, which will be placed in urban target areas, could include such topics as an infant death due to the mother's having too many children too close together, an ill mother who is too tired to take care of her many children, a death or serious illness due to an illegal abortion. Tape programs.

4. Write four feature or news stories to be inserted in target area newspapers on a weekly basis in March. Articles should be on the same theme as weekly radio programs–maternal and child health benefits with family planning.

5. Begin work on three additional booklets for distribution in postpartum and dropout programs. Design one on the pill, one on the IUD (Loop), and one on sterilization operations for the man and the woman. Be sure to include the slogan and symbol of the Family Planning Program. Write simple copy and have type set.

6. Take flipbooks to printer and have 4,000 copies of each printed by the end of the month. Complete picture taking for filmstrips.

7. Send out newsletter to health community mailing list. For content, see, p. 90.

NOVEMBER

1. Develop a mailing list for religious and community leaders. Have at least 1,000 names and addresses by the end of month.

2. Work up four dramas for April radio programs around theme of economic benefits of family planning. The topics could include problems related to feeding, housing, and clothing a large family as compared to those encountered by small families. Tape programs.

3. Have scripts for five television commercials completed by end of month using slogan and symbol of family planning program at the end of each. Consider using a sixty-second and a thirty-second version of the same advertisement in order to double the number of commercials without doubling the creative work.

4. Work up four news or feature articles for April on same theme as used in April radio programs and April article in women's magazine–economic benefits of family planning.

5. Contact indigenous media popular in Valhalla and aid in preparation of scripts for puppet shows or drama troops. Ask performers to begin using these plays in February and continue for rest of year.

6. Arrange for simple art work for the three brochures on specific methods and have material ready for printer by end of month.

7. Arrange for printing of filmstrip scripts, have pictures made into strips with appropriate titles, and have final prints made in laboratory.

8. Send out newsletter to elite and political and provincial elite mailing lists. For content, see p. 89.

DECEMBER

1. Develop a mailing list for special groups. (See p. .) Aim for 1,000 names and addresses by the end of the month.

2. Work up four dramas for May radio programs in urban target areas around theme of educational benefits related to family planning. Topics covered might include the problems of an overcrowded classroom, disadvantages of illiteracy in terms of employment, and expense of high education. Tape programs.

3. Have story boards completed for television commercials (if story boards are necessary) during the first part of the month and begin filming.

4. Be sure women's magazine has article on the availability of birth control (commissioned in August) in time to appear in February publication.

5. Write four news or feature articles for May insertion in newspapers on same topic as weekly May radio spots—education and family planning.

6. Begin working up four question-and-answer columns for the newspapers in the four target cities on the subject of family planning and health. The format might include three letters and three answers each week, discussing such topics as the various methods of birth control, their safety and effectiveness; and advising readers where to go for services. A column of this sort becomes self-sustaining after a few months in that readers write in letters that can be answered in the paper. The first few months, however, the letters to the column must be made up. Be sure to include in the column an address where readers may send letters. Contact newspapers in the four target cities and schedule the column on a weekly basis beginning in February.

7. Develop a series of slides to be used in movie houses and special trailers (approximately thirty-seconds long) to be run between features. The television ads could be modified and adapted for such use. Contact movie houses and schedule runs to begin first week in February. Be certain that the slides and trailers include the family planning symbol and slogan.

8. Take the three brochures on specific methods to the printer and have 10,000 of each printed by end of the month.

9. Send newsletter to special groups mailing list. The primary message should consist of the general approach mentioned on p. 90, and should discuss the benefits for national economy involved in reduced population growth.

JANUARY

1. Develop a mailing list for educational leaders and have 500 names and addresses by the end of January.

2. Work up four radio dramas to be sent to stations in the four target cities in June on the theme of religion and family planning. Christian and Muslim leaders could discuss with members of their respective religious organizations the various ways in which their religious beliefs and family planning are compatible. Tape programs.

3. Complete filming of television commercials by middle of month and have one copy of each made for each television station in target areas.

4. Send women's magazine article for March on maternal and child health benefits in family planning.

5. Write four articles for newspapers to appear in target cities each week in June on same topic as weekly radio spots for June—religion and family planning.

6. Write four question-and-answer columns for insertion in March newspapers in four target cities.

7. Complete slides and trailers for cinemas.

8. Distribute appropriate numbers of brochures, flip-books, and filmstrips to all family planning clinics in four target cities.

9. Begin organizing Dropout Program in conjunction with all family planning clinics in four target cities. During January make sure that all field workers are properly educated about methods of contraception and have a sufficient supply of booklets to give dropouts. Schedule program to begin the first week in February.

10. Send newsletters to elite and political, provincial elites, and religious and community leaders mailing lists. For content, see pp. 89, 90, and 91.

FEBRUARY

1. Take radio program tapes for February to target cities' stations and check scheduling. Theme for February: couples now have a choice about family size.

2. Deliver television commercials to stations in target cities and re-check scheduling. Spots are to run interchangeably with approximately six showings a week for the rest of the year.

3. Send women's magazine article for April publication on economic benefits of family planning.

4. *Newspapers.* You have now developed three items to be inserted each week in the major newspapers in target cities: feature or news stories, ads, weekly question-and-answer columns. Send to newspapers on a weekly or monthly basis, whichever they require. The advertisement, however, should need to be inserted only once.

5. Begin running slides and trailers between features at cinemas. Check the scheduling for the rest of the year.

6. Begin organizing Postpartum Program in four target cities in Valhalla; distribute appropriate numbers of brochures, flipbooks, and filmstrips to all maternity hospitals and clinics; arrange for nurses and/or midwives to present materials and offer each woman an appointment at a family planning clinic. Plan for program to get underway the first week in March. (For more information, see Annual Work Plan, p. 93.)

7. See that Dropout Program begins as scheduled in four target cities.

8. Send out newsletter to health community leaders, communications media, and special groups mailing lists. For content of letter to health community leaders and communications media, see p. 90. For special groups in addition to the general approach mentioned, see p. 93, discuss the specific economic benefits each employer will experience if he incorporates family planning in his health services to employees. For additional information, see Annual Work Plan, p. 94.

MARCH

1. Take radio program tapes to stations in target cities and check scheduling. Theme for March: better health for mothers and children with family planning.

2. Send women's magazine article for May publication on educational benefits related to family planning.

3. Send question-and-answer column and feature or news stories for March to newspapers.

4. See that Postpartum Program begins as scheduled.

5. Continue Dropout Program.

6. Send newsletter to elite and political, provincial elite, religious and community leaders, and educational leaders mailing lists. For content, see pp. 89, 90, and 91.

7. Begin to organize a one-day conference for approximately twenty-five of the most influential people on the special groups mailing list. Those in attendance should be the leaders of labor unions, key people in the military and armed services, major employers, and leaders in government and municipal organizations. Choose only those people who live in one of the four target cities in Valhalla. Pick a date in May and arrange for a conference room in Verona. Send letters of invitation.

8. Contact weekly and daily newspapers in rural areas of Valhalla and offer them weekly question-and-answer column. All this will require is expansion of the mailing list, since the column is already being written each week for the four target cities.

9. Contact radio stations in rural areas and arrange for weekly program of the type now running on stations in the four target cities. If urban programs are not suitable for rural audiences, rewrite and adapt scripts. Start programs with theme used in February in the cities: couples now have a choice about family size. Schedule programs to begin running in April.

APRIL

1. Take radio program tapes to stations in target cities and check scheduling. Theme for April: economic benefits related to family planning.

2. Send women's magazine article for June publication on religious sanction of family planning.

3. The weekly question-and-answer column should be receiving letters each week from readers. Use the twelve best letters, answer them in four separate columns and insert in urban and rural newspapers. All the other letters should be answered directly. Send feature or news stories for April to newspapers in target cities.

4. Continue Postpartum Program.

5. Continue Dropout Program.

6. Send newsletter to health community leaders, communications media, and special groups mailing lists. For the latter, continue to stress the economic advantages of incorporating family planning in health services to employees (for example, contraceptive services are cheaper than maternity benefits).

7. Arrange for the Minister of Information and Broadcasting and other members of the Family Planning Advisory Board to speak to the Special Groups Conference in May. Finalize conference plans.

8. Begin radio programs in rural areas. Theme: couples now have a choice about family size.

9. Contact health educators in a five-province area and invite them to a two-day conference in a central location in May. For more information on details of conference, see Annual Work Plan.

MAY

1. See that radio tapes for May are properly scheduled in target cities. Theme for May: educational benefits related to family planning.

2. Write question-and-answer column (as in April) and insert in newspapers in rural and urban areas. Send feature or news stories to papers in target cities.

3. Continue Postpartum Program and begin making plans for expansion for next year.

4. Continue Dropout Program and begin making plans for expansion for next year.

5. Send newsletter to elite and political, provincial elites, religious and community leaders, and educational leaders.

6. Hold Conference for Special Groups Leaders in Verona. Arrange, if possible, for contraceptive services to be given along with health services in the organizations represented at the conference. Schedule contraceptive programs to begin the first of next year.

7. Send radio programs to rural stations. Theme this month: better health for mothers and children with family planning.

8. Hold first conference for health educators.

9. Begin organizing a conference to be held in June for key people in the Ministry of Education to discuss the possibility of including population education materials in school curricula.

JUNE

1. See that June radio tapes are properly scheduled. Theme for June for stations in target cities: religious sanction of family planning.

2. Write question-and-answer columns and insert in newspapers in rural and urban areas. Send feature or news stories for June to newspapers in target cities.

3. Continue Postpartum Program and plans for next year's expansion.

4. Continue Dropout Program and plans for next year's expansion.

5. Send newsletter to health community, communications media, special groups mailing lists. Mention important aspects of the May conference in the newsletter to special groups.

6. Send rural radio tapes to stations for month. Theme: economic benefits of family planning.

7. Hold a conference on population education for key people in the Ministry of Education and begin, if possible, making plans for the inclusion of population education materials in school curricula.

Authors' Note: *The authors wish to thank William O. Sweeney of the Ford Foundation for portions of the work plan.*

WORK PLAN: GHANA

MARTIN TAY, JANET ADU-ABOAGYA,
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The Ghana National Family Planning Program proposes as its first priority the organization of six national campaigns.

Awareness Campaign

The objectives of the campaign are to make people aware of:

1. A stated concept of family planning.
2. The idea that family planning is good.
3. The relation of the "Red Triangle"—the symbol of the Ghana National Family Planning Program—to the concept of family planning.

STRATEGY TO ACCOMPLISH OBJECTIVES

1. Mounting awareness posters in all centers with family planning facilities and in centers where services are about to start. Displaying posters also in trains, city buses, entrances to departmental stores, offices and other public places.
2. Providing car labels for all state transport vehicles, mammy wagons, lorries, and private cars.
3. Converting existing census hoardings for use for family planning awareness materials.
4. Making and exhibiting slides in cinema houses, on TV, and in cinema vans.
5. Making permanent metal "Red Triangle" signs for centers have family planning facilities.

6. Conducting TV and radio spot announcements.
7. Showing short film trailers in cinema houses.
8. Providing "Red Triangle" badges for all family planning personnel and marking the "Red Triangle" on all family planning equipment and materials.
9. Launching regional programs with public ceremonies and ensuring the participation of regional leaders. Providing badges and printed materials for all participants and arranging extensive press, radio, and TV coverage.

TARGET GROUPS

Awareness of family planning by the largest possible number of people in the country is the goal. The Awareness Campaign will start in areas where services are now available and will be extended to other sections prior to the provision of service facilities. The target groups are:

1. Elite and political
2. Health community
3. Communication media
4. Clients of health services
5. Local leaders
6. Religious community leaders
7. Special groups
8. Other members of general public

MEDIA

1. Printed material
2. Hoardings
3. Metal signs
4. Car stickers
5. Cinema
6. Badges
7. "Red Triangle" sign on all Family Planning Program letterheads, property, and on government pens and pencils.
8. Radio and TV
9. Personal contact
10. Mailings

Legitimation Campaign

The objectives of the legitimation campaign are to promote awareness that family planning:

1. has the support of the government;

2. is approved by respected and prestigious people; and
3. is both necessary and beneficial to the country.

STRATEGY TO ACCOMPLISH OBJECTIVES

1. Distributing pamphlet already printed, "Family Planning Why," through all post office boxes and pamphlet racks in public places and through field workers.

2. Obtaining and using on TV, radio, and in print, endorsements and expressions of support from prominent and respected people.

3. Radio and TV use of tape recorded utterances from people from all walks of life.

4. Making and showing film interviews with local chiefs in cinema houses, cinema vans, and on TV.

5. Providing information kits for speakers, religious and political leaders, local government officials, labor union leaders, teacher training faculty, Centre for Civic Education, social welfare, and youth and rural development workers.

6. Providing metal badges for acceptors, youth groups, market women, specialised groups, and other sections of the general public.

7. Personal approach to key ministers, government officials, opposition leaders, doctors, and women leaders.

TARGET GROUPS

It is essential that all sections of the population be informed and believe that family planning is approved by national and local prominent and respected people. The aim of the campaign will be to obtain evidence of support and approval from all groups and to bring this to the attention of the public.

1. Elite and political
   - Presidential commission and Cabinet members
   - Members of National Assembly
   - Senior civil servants
   - Business and industrial leaders
   - University professors and administrators
2. Regional elite
   - Regional Chief Executives
   - Chairmen of House of Chiefs
   - Paramount and divisional chiefs
   - Regional senior civil servants
   - Senior staff of business and industrial organizations

3. Health community
   - Physicians
   - Nurses
   - Family planning personnel
   - Medical and para-medical personnel
4. Communication media
   - Newspaper editors
   - Radio and TV program officers
5. Clients of health services
   - Women attending health clinics
   - Men attending health clinics
6. Religious community leaders
   - Christian leaders
   - Muslim leaders
   - Indigenous religious leaders
7. Special groups
   - National Service Corps
   - National Labour Unions
   - Military and police services
   - Workers Brigade
   - Women's groups
   - Voluntary agencies
   - Major employers
8. Educational institutions
   - Educational personnel
   - Students and pupils
9. General public
   - Urban men and women
   - Rural men and women

MEDIA

1. Press
2. Radio and TV
3. Personal contact
4. Publications
5. Cinema
6. Mailings

Population Problem Campaign

The objectives of this campaign are to promote knowledge about the population problem and show:

1. Population trends in Ghana and in the world as a whole.
2. Relation of population growth to development planning.

3. Activities and accomplishments of the national Family Planning Program.

STRATEGY TO ACCOMPLISH OBJECTIVES

1. Providing steady flow of newspaper articles on population problems at home and abroad.
2. Conducting radio and TV panel programs, showing NBC films, Walt Disney film, and others.
3. Providing newsletter for family planning workers as well as medical and para-medical personnel.
4. Reprinting "Ghana's Population Policy" for distribution to selected people. Printing the population policy in installments in newspapers will be considered.
5. Introducing population barometer in newspapers showing each week the increase over the previous weeks. Installation of barometer boards in public places will be considered.
6. Publishing of the pamphlet, "The People Problem," showing graphically Ghana's population problem.
7. Making documentary films showing the nature of the problem in Ghana.
8. Preparing a mailing list of 2,000 key Ghanaians.
9. Conducting a three-day seminar on "The Consequences of Population Growth."

TARGET GROUPS

1. Elite and political
   - Presidential Commission and Cabinet Members
   - Members of National Assembly
   - Senior civil servants
   - Business and industrial leaders
   - University professors and administrators
   - Teachers
2. Regional elite
   - Regional Chief Executives
   - Chairmen of Houses of Chiefs
   - Paramount and divisional Chiefs
   - Regional senior civil servants
   - Senior staff of business and industrial organizations
   - Teachers
3. Health community
   - Physicians
   - Nurses
   - Family planning personnel
   - Medical and para-medical personnel

4. Communications media
   - Newspaper editors
   - Radio and TV programmers
5. Local leaders
   - Chiefs
   - Chairmen of local councils
6. Religious community leaders
   - Christian leaders
   - Muslim leaders
   - Indigenous religious leaders
7. Special groups
   - National Service Corps
   - National Youth Clubs
   - Labor unions
   - Military and police services
   - Workers Brigade
   - Women's groups
   - Voluntary agencies
   - Major employers
8. Educational institutions
   - Educational personnel
   - Students and pupils

MEDIA

1. Personal contact
2. Radio and TV
3. Press
4. Direct mailings
5. Cinema

Contraceptive Campaign

The objectives of the contraceptive campaign are to provide knowledge on modern methods of contraceptives with emphasis on their: safety; acceptability; effectiveness; cost; availability; and methods of use.

STRATEGY TO ACCOMPLISH OBJECTIVES

1. Publishing and distributing the pamphlet, "Family Planning How." Translating and publishing the pamphlet in the national languages.

2. Making a twenty-to-thirty-minute film, showing what contraceptive services are provided in Ghana and duplicating the film for use in cinema houses and on cinema vans.

3. Advertising clinic hours and locations in English and national languages newspapers.

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4. Publishing posters for each region listing time and location of services.

5. Preparing wallet-size card showing clinic hours and location.

6. Providing advertisements for selected methods in support of commercial distribution program.

7. Providing regular spot announcements of location and hours of service in each region.

8. Making arrangements for panel discussion of contraceptive methods by medical personnel on radio and TV.

9. Developing a "Dear Abby" type weekly column for radio and newspapers for answering common questions about the various methods of contraception.

TARGET GROUPS

All potential users of contraceptives with emphasis on those likely to accept use.

1. Clients of health services
   - Women attending health clinics
   - Women attending family planning clinics
   - Men attending health clinics
   - Postpartum women
   - Dropout women
2. General public
   - Rural men and women
   - Urban men and women
3. Non-medical field personnel
   - Adult education officers
   - Youth and Rural Community Development workers
   - Social workers
   - Agricultural extension workers
   - Nutritionists
4. Special groups
   - National Service Corps
   - Labor unions
   - Military and police services
   - Workers Brigade
   - Women's groups
   - Voluntary agencies
5. Educational institutions
   - Educational personnel
   - Students and pupils
   - Unmarried girls and boys

MEDIA

1. Personal contact
2. Lectures
3. Publications
4. Radio and TV
5. Cinema
6. Press

Motivation Campaign

The objectives of the motivation campaign are to promote readiness to use contraceptives and to encourage the desire for smaller families through: (1) appreciation of the advantages of spacing one's family: and (2) knowledge of the benefits of small families.

STRATEGY TO ACHIEVE OBJECTIVES

1. Publishing and distributing photo novels and comic books without words and other audiovisual aids.
2. Preparing "soap opera" cartoons and translating them into the national languages.
3. Recording messages for use on loudspeakers in clinics.
4. Preparing films of puppet shows.
5. Preparing and printing pamphlet entitled "Family Planning When," and translating it into the national languages.
6. Approaching local groups to arrange discussions on family planning.
7. Arranging panel discussions on radio and TV.

TARGET GROUPS

1. Married couples of child-bearing age.
2. Adolescent boys and girls

MEDIA

1. Press
2. Radio and TV
3. Personal contact
4. Publications
5. Cinema

Reassurance Campaign

The objectives of the reassurance campaign are to reassure and allay fears of contraceptive users about contraceptive safety, effectiveness, and appropriateness.

STRATEGY TO ACCOMPLISH OBJECTIVES

1. Introducing question-and-answer column in newspapers and on radio.

2. Recording and printing statements from satisfied users.

3. Arranging radio discussions between physicians and satisfied users.

4. Correcting promptly rumors about the use of contraceptives.

5. Devising a system of feedback from local clinics and field workers.

TARGET GROUP

Contraceptive users.

MEDIA

1. Press
2. Publications
3. Radio and TV
4. Personal contact

Annual Work Plan

AWARENESS CAMPAIGN

1. Mount awareness posters in trains, city buses, entrances of department stores, offices, and in all centers with clinic services and in centers where services are likely to be started.

2. Distribute car labels to all state transport organizations, to the Road Transport Unions, and private car owners.

3. Contact census organizers and acquire census hoardings.

4. Repair and repaint acquired census hoardings

5. Display awareness posters on hoardings and consider painting posters on plywood to be mounted on hoardings.

6. Design and produce slides for cinema.

7. Make permanent metal "Red Triangle" sign for all family planning clinics.

8. Develop slogans for thirteen-week radio and TV spot campaign to be run not less than twice daily. Message to support "slogans," "Family Planning–Better Life," "Family planning lets you have only the number of children you really want," "Red Triangle stands for family planning" (five or six different messages).

9. Explore possibility of short film trailers.

10. Prepare for launching family planning program in regions.

11. Launch family planning program in regions at two-week intervals. Distribute family planning badges to all participants.

12. Instruct all manufacturers of family planning equipment and material to mark them with "Red Triangle" symbol.

13. Explore possibility of having government pens and pencils marked with the "Red Triangle."

14. Arrange shooting and editing of documentary film for TV.

15. Make copies for use in cinema van campaign.

16. Select appropriate documentary films for cinema vans.

17. Distribute regularly to about 2,000 key Ghanaians on mailing list such items as population chronicle.

18. Contact lecturers for a two to three-day national seminar on "The Consequences of Population Growth."

19. Send invitations to national seminar participants.

20. Organize seminar.

21. Prepare flip charts for use in clinics and by health and family planning personnel.

LEGITIMATION CAMPAIGN

1. Develop a mailing list of about 2,000 people in target audience.

2. Distribute the pamphlet, "Family Planning Why," through all post office boxes, pamphlet racks, and field workers.

3. Obtain, record, print, and make slides of endorsements and expressions of support from prominent and respected people and from people of all walks of life.

4. Contact and make arrangement for film interviews with local chiefs.

5. Prepare and assemble material for information kits for speakers.

6. Arrange appointments with individual members of the elite and political groups to obtain their support for the program.

7. Feed radio and TV with tape recorded endorsements and expressions of support.

8. Make film interviews with local chiefs.

9. Discuss family planning program with as many members of the elite and political groups as possible.

10. Distribute metal badges to market women and specialized groups.

POPULATION PROBLEM CAMPAIGN

1. Write and supply on a regular basis one article a week on population problems at home and abroad.

2. Contact suitable people for regular, one-a-month panel discussions on radio and TV.

3. Make arrangements with radio and TV programmers for panel discussions.

4. Make arrangements with TV, cinema houses, and Ministry of Information for the use of NBC, Walt Disney, and other appropriate films as fillers.

5. Provide slogan for use as filler in newspapers.

6. Collect material and print newsletters for audiences.

7. Reprint "Population Policy."

8. Distribute newsletter and "Population Policy" to appropriate audiences on mailing list.

9. Consider printing "Population Policy" in installments in newspapers.

10. Design for use in newspapers "Population Barometer" showing Ghana's population each week and the increase over the previous week.

11. Make and install Barometer Boxes in public places.

12. Prepare and test the pamphlet "The People Problem," showing graphically Ghana's population problem.

13. Print pamphlet, "The People Problem."

14. Distribute to appropriate audiences.

15. Write scripts for twenty-to-thirty-minute TV documentary films showing nature of the population problem in Ghana.

16. Assemble information kits on the population problem in Ghana in particular and in the world at large.

CONTRACEPTIVE CAMPAIGN

1. Prepare and test material for the pamphlet, "Family Planning How."

2. Translate script into national languages.

3. Print and distribute pamphlet, "Family Planning How."

4. Write script for twenty-to-thirty-minute film showing how contraceptive services are provided in Ghana.

5. Arrange shooting, editing, and duplicating of the film for use in cinema houses and on cinema vans.

6. Place advertisement of clinic locations and hours in English and national languages newspapers.

7. Design and publish posters for each region listing location and time of services.

8. Prepare wallet-size card showing clinic locations and hours.

9. Provide regular spot announcement of locations and hours of services in each region.

10. Provide advertisement for selected methods in support of commercial distribution program.

11. Contact medical personnel and arrange discussion of contraceptive methods on radio and TV.

12. Arrange talks for women's organizations on various methods of contraception.

13. Develop a weekly column for radio and newspapers for answering common questions about the various methods of contraception.

14. Organize programs in main regional hospitals and clinics where family planning services are available for women who have just given birth. Postpartum women in all main regional hospitals and family planning clinics will be approached by a nurse or midwife sometime after the birth of their babies and before they leave the hospital, informed about the different methods of contraception, and offered contraceptive services immediately if they so desire.

15. Write scripts for filmstrips on modern methods of contraception, prepare flip charts to be shown to groups of postpartum women while they are still in the hospitals, and distribute booklet, "Family Planning How," to the literate. Before a postpartum woman leaves the hospital she will be offered an appointment at a family planning clinic at the same time that she returns for her postpartum checkup. During 1970-71, this program will be organized in main regional maternity hospitals and clinics offering family planning services with plans to extend services to all urban and rural areas when feasible.

16. Program will be organized for those women who have stopped receiving services at family planning clinics. Field workers will contact each woman, inquire about her reasons for dropping out of the program, provide her with the appropriate booklets, and offer her another appointment at the clinic. This plan will be started at main regional maternity hospitals and clinics offering family planning services and later extended to all the urban and rural areas.

17. During 1970-71, an effort will be made to encourage employers of large groups of people to incorporate contraceptive services in their health services to employees.

18. Assemble information kits on the safety, acceptability, effectiveness, cost, and availability of modern methods of contraception.

MOTIVATION CAMPAIGN

1. Prepare photo novels and comic books without words for distribution to married couples and adolescent boys and girls.

2. Prepare flipcharts and other visual aids for use in clinics and at talks by health officers and family planning personnel.

3. Prepare cartoon stories on the "soap opera" model and translate them into the national languages.

4. Record messages highlighting the advantages of spacing one's family and the benefits of small families for use in clinics and health centers and by women's and men's discussion groups.

5. Write script and prepare films of puppet shows for use in cinema vans and on TV.

6. Prepare and print pamphlet entitled, "Family Planning When," and translate it into the national languages for distribution to audiences.

7. Approach local discussion groups to arrange discussions of family planning at their meetings.

8. Arrange panel discussions on radio and TV.

9. Assemble information kit on use of contraceptives and benefits of smaller families.

10. Contact and encourage local drama groups to organize plays on the benefits of smaller families.

REASSURANCE CAMPAIGN

1. Plan and introduce question-and-answer columns in newspapers and on radio. Message: safety, effectiveness, and appropriateness of contraceptives.

2. Obtain, record, and print statements from satisfied users of contraceptives.

3. Arrange radio discussions by physicians and satisfied users.

4. Correct promptly in press, radio, and TV rumors about use of contraceptives.

5. Assemble information kits on safety, effectiveness, and appropriateness of contraceptives.

6. Devise a questionnaire to obtain feedback from local clinics and field workers.

Monthly Work Plan

JULY 1970

1. Mount awareness posters in trains and city buses, entrances of department stores, offices, and at all centers with clinic services, and at centers where services are likely to be started (posters already printed).

Also distribute car labels to all state transport organizations, to the Road Transport Unions, and to private car owners (car labels already printed).

2. Place order for permanent metal "Red Triangle" signboards for family planning clinics.

3. Develop a mailing list of about 2,000 people in target audience.

4. Contact census organizers for the acquisition of census hoardings.

5. Contact, make arrangements for, and produce film interviews with local chiefs.

6. Discuss family planning program with as many members of the elite and the political group as possible.

7. Contact suitable people and make arrangements for regular, monthly panel discussions on radio and TV on awareness campaign.

8. Make arrangement with TV, cinema houses, and Ministry of Information for use of NBC, Walt Disney, and other appropriate films as fillers.

9. Place advertisements for clinic hours and locations in English and national languages newspapers and provide regular spot announcements on the radio of same for each region (revise when necessary).

10. Prepare and test material for the pamphlet, "Family Planning How."

11. Design and publish posters for each region listing time and location of family planning clinical services (revise when necessary).

12. Prepare and provide advertisements for selected methods in support of commercial distribution of contraceptives (revise when necessary).

AUGUST 1970

1. Continue to mount awareness posters in trains and city buses, entrances of department stores, offices, and at all

centers with clinic services, and at centers where services are likely to be started. Also, continue to distribute car labels to all state transport organizations, to the Road Transport Unions, and to private car owners.

2. Complete mailing list.

3. Make preparation for launching family planning program in regions.

4. Translate script of "Family Planning How" into the national languages. Print and distribute pamphlets.

5. Repair and repaint acquired census hoardings and display awareness posters on them. Also consider painting awareness posters on plywood to be mounted on the hoardings in each region.

6. Contact medical personnel and make arrangements for discussion of contraceptive methods on radio and TV.

7. Arrange panel discussion on radio and TV on the advantages of planning one's family and benefits of smaller families.

8. Explore possibility of having government pens and pencils marked with the "Red Triangle" symbol, and place order.

9. Approach local discussion groups to arrange discussions on the legitimation of the family planning program.

10. Prepare cartoon stories, using a "soap opera" model, and translate them into the national languages.

11. Organize a program in main regional hospitals and clinics where family planning services are available for women who have just given birth. Postpartum women in all main regional hospitals and family planning clinics will be approached by a nurse or midwife sometime after the birth of their babies and before they leave the hospital, informed about different methods of contraception, and offered contraceptive services immediately if they so desire (action by Service Division).

SEPTEMBER 1970

1. Continue display of awareness posters on hoardings and painting others on plywood to be mounted on hoardings in the regions.

2. Instruct all manufacturers of family planning equipment and material to mark them with "Red Triangle" symbol.

3. Distribute "Family Planning Why" through all post office boxes, pamphlet racks, and field workers.

4. Continue personal discussion of family planning program with members of the elite and political group.

5. Prepare and test pamphlet, "The People Problem," showing graphically Ghana's population problem.

6. Continue regular distribution of items such as population chronicle to about 2,000 key Ghanaians on mailing list.

7. Write script for twenty-to-thirty-minute film showing provision of contraceptive services in Ghana and arrange shooting, editing, and duplication of the film for use in cinema houses and on cinema vans.

8. Prepare wallet-size cards showing clinic locations and hours for distribution to target audience.

9. Arrange regular spot announcements of locations and hours of family planning services in each region.

10. Arrange talks for women's organizations on various methods of contraception.

11. Write script for filmstrips on modern methods of contraception and prepare flipcharts to be shown to groups of postpartum women while they are still in the hospitals; also distribute booklet, "Family Planning How," to the literates. Before a postpartum woman leaves the hospital, she will be offered an appointment at the family planning clinic at the same time that she returns for her postpartum checkup. During 1970-71, this program will be organized in main regional maternity hospitals and clinics offering family planning services with plans to extend services to all urban and rural areas when feasible.

12. Prepare and print pamphlet entitled, "Family Planning When," and translate it into national languages for distribution to target audiences.

13. Contact and arrange for local drama groups to organize plays depicting the benefits of smaller families.

14. Arrange radio discussions by physicians and satisfied users of contraceptives.

OCTOBER 1970

1. Mounting of awareness posters at designated places will continue. Also continue distribution of car labels.

2. Launch family planning program in regions at two-week intervals. Distribute family planning badges to all participants and arrange extensive press, radio, and TV coverage for the ceremonies.

3. Design and produce slides for cinema on awareness campaign.

4. Develop slogans for thirteen-week radio and TV spot campaign to be run not less than twice daily with messages to support Family Planning: "Family Planning–Better Life," "Family planning lets you have only the number of children you

really want," " 'Red Triangle' stands for 'Family Planning.' " Develop five or six different messages.

5. Continue distribution of the pamphlet "Family Planning Why."

6. Show film interviews with local chiefs.

7. Continue discussions of family planning program with elite and political group.

8. Arrange panel discussions on radio and TV on the legitimation program.

9. Provide slogans for use as fillers in newspapers.

10. Collect material and print newsletters for audiences.

11. Reprint "Population Policy."

12. Print pamphlet, "The People Problem," and distribute regularly.

13. Continue regular spot announcements of clinic locations and hours of service in each region.

14. Contact medical personnel and arrange discussion of contraceptive methods on radio and TV.

15. Write script and prepare film of puppet shows for use in cinema vans and on TV.

NOVEMBER 1970

1. Inspect awareness posters, replace where necessary, and continue distribution of car labels.

2. Start thirteen-week radio and TV campaign of messages supporting family planning.

3. Continue launching family planning program in regions.

4. Distribute metal badges to market women and specialized groups on appropriate occasions.

5. Arrange panel discussions of population problem on radio and TV.

6. Continue provision of slogans for use as fillers in newspapers.

7. Distribute newsletter and "Population Policy" to appropriate audience on mailing list.

8. Continue regular spot announcement of clinic locations and hours of service in each region.

9. Develop a weekly column for radio and newspapers answering common questions about various methods of contraception.

10. Prepare photo novels and comic books without words for distribution to married couples and adolescent boys and girls.

11. Plan and introduce question-and-answer columns in newspapers and on the radio on the safety, effectiveness, and appropriateness of contraceptives.

12. Obtain, record, and print statements from satisfied users of contraceptives.

13. Assemble information kits to aid speakers on use of contraceptives and the benefits of smaller families.

DECEMBER 1970

1. Continue inspection and replacement of awareness posters. Also continue distribution of car labels.

2. Ensure continuation of thirteen-week radio and TV spot campaign of slogans in support of family planning.

3. Continue regional launching of family planning program.

4. Plan national seminar on consequences of population growth. Contact suitable lecturers, issue invitations to participants, and organize seminar.

5. Continue discussion on family planning program with elite and political groups.

6. Continue distribution of metal badges to market women and specialized groups on appropriate occasions.

7. Assemble information kits on the population problem in Ghana in particular and in the world at large.

8. Regularly write and supply one newspaper article a week on population problem at home and abroad.

9. Continue panel discussions on population problem on radio and TV.

10. Write scripts for twenty-to-thirty-minute documentary films showing the nature of the population problem in Ghana for TV and cinema.

11. Continue radio spot announcements of locations and hours of service of family planning clinic services in each region.

12. Continue discussion of contraceptive methods by medical personnel on radio and TV.

13. Prepare flipcharts and other visual aids for use in clinics and at talks by health officers and family planning personnel.

14. Approach local groups to arrange discussions on use of contraceptives and the need for smaller families.

15. Assemble information kits on the safety, effectiveness, and appropriateness of contraceptives.

16. Start planning for 1971-72.

JANUARY 1971

1. Explore possibility of short film trailers.
2. Launchings of regional family planning program continue.
3. Arrange shooting and editing of documentary film on awareness campaign for TV and make copies for use in cinema vans.
4. Obtain, record, print, and make slides of endorsements and expressions of support from prominent and respected people and from people from all walks of life.
5. Assemble information kits on the population problem in Ghana in particular and in the world at large.
6. During this month, effort will be made to encourage employers of large groups of people to incorporate contraceptive services into their employees' health services.
7. Radio spot announcements of locations and hours of regional clinic services continue.
8. Discussions of methods of contraception by women's organizations continue.
9. Print "soap opera" cartoon stories.
10. Radio and TV discussions by physicians and satisfied users continue.
11. Continue with plans for 1971-72 annual estimates.

FEBRUARY 1971

1. Ensure change of awareness posters at designated spots and continue distribution of car labels.
2. Arrange shooting of short film trailers if possible.
3. Continue supply of newspaper articles on population problem at home and abroad.
4. Radio and TV panel discussions on population problem continue.
5. Consider printing "Population Policy" in installments in newspaper.
6. Announcements of locations and hours of family planning services in each region continue to be made on the radio.
7. Local discussion groups continue their discussions on the motivation campaign.
8. Devise a questionnaire to obtain feedback from local clinics and field workers on the reassurance campaign.
9. Show on TV, slides of endorsements and expressions of support obtained from prominent and respected people. Also publish statements in newspapers.
10. Finalize plans for 1971-72 annual estimates.

MARCH 1971

1. Replacement of awareness posters and distribution of car labels continue.

2. Arrange to show short film trailers on awareness campaign.

3. Arrange another seminar on population growth problem.

4. Newspaper articles on population problems at home and abroad continue.

5. Panel discussions on radio and TV on population problem continue.

6. Print "Population Policy" in installments in newspapers.

7. Design for use in newspapers "Population Barometer" showing Ghana's population each week and the increase over the previous week.

8. Make and install barometer showing increases in Ghana population in public places.

9. Radio announcements of locations and hours of family planning services in each region continue.

10. Arrange another talk on the various methods of contraception for women's organizations. Also repeat radio discussions by physicians and satisfied users.

APRIL 1971

1. Awareness campaign with posters and car labels continues.

2. Explore possibility of having government pens and pencils marked with the "Red Triangle" symbol.

3. Continue discussions of family planning program with elite and political groups.

4. Arrange appointments and contact individual members of elite and political groups to obtain their support for the program.

5. Repeat newspaper articles on population problem.

6. Continue panel discussions on population problem on radio and TV.

7. Repeat use of NBC, Walt Disney, and other appropriate films as fillers.

8. Newspaper installments on "Population Policy" will continue.

9. Ensure change of population figures on barometer in public places.

10. Radio spot announcements of locations and hours of family planning services in each region continue.

11. Repeat medical personnel discussion of contraceptive methods on radio and TV.

12. Local discussion groups continue discussion of motivation campaign.

MAY 1971

1. Awareness campaign with posters and car labels continues.

2. Continue TV showing of slides of endorsements and expressions of support. Also repeat for newspapers.

3. Continue face-to-face talks with individual members of elite and political groups to obtain their support for the program.

4. Newspaper articles on population problem will continue and should be effective at this period when National Assembly will soon discuss the country's annual estimates.

5. Point 4 also applies to radio and TV panel discussions.

6. Ensure that "Population Policy" pamphlet is distributed to target groups.

7. Change population figures on barometer in public places.

8. Supply information kits on population problem to target groups.

9. Announcements of locations and hours of services in each region continue.

10. Arrange another discussion by physicians and satisfied users on radio and TV.

JUNE 1971

1. Complete awareness campaign activities.

2. Complete legitimation campaign activities.

3. Continue postpartum program and make plans in annual estimates for expansion during 1971-72.

4. Continue dropout program and make plans in annual estimates for expansion during 1971-72.

5. Hold a conference on population problem for key people in government.

WORK PLAN: KENYA

E. R. IKIUTWA, G. KOGONDU,
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Objectives

The primary objective is to intensify the family planning information and education program by:

1. Identifying persons who can provide access to large numbers of possible recipients and organize family planning information programs.
2. Making people aware that there are safe and reliable methods of family planning as well as informing them that free services can be obtained in all government hospitals and health centers.
3. Solidifying support for family planning activities among opinion leaders.
4. Exploring with educational leaders the possibility of including sex education content in school curricula.
5. Informing national leaders, professional groups, and other opinion leaders of the social, economic, and health implications of rapid increases in population.
6. Educating employees of all government and private organizations concerned with development about their involvement in the promotion of family planning.
7. Supplying information to personnel in hospitals and health clinics.

8. Directing information to people in charge of mass media.

9. Increasing the number of field educators and if possible recruiting and training volunteers.

Strategy

Leaders who can provide access to large numbers of potential recipients (industrial and business leaders, members of Parliament, senior civil servants, trade unionists, health administrators, educational leaders) are important to the success of the family planning program. Contraceptive services integrated into existing health service programs can reach a large number of people in a short period. Such contact aids in maximizing the impact of an overall family planning program and provides a group of acceptors who help to establish the use of family planning as an acceptable behavior.

The infrastructure for delivery of health services in Kenya includes 477 health clinics in rural areas serving most rural residents. Personnel of already existing organizations—both governmental and private—who are operating such clinics, should be encouraged to upgrade family planning services in these clinics to rapidly increase the acceptance rate.

In order to insure continued support of opinion leaders, it is necessary to regularly inform these leaders of the program's progress, plans, and goals.

The long-term success of a family planning program will be assured if school-age children are properly educated as to effects of high fertility rates on national economy as well as on families and individuals and if sex education is integrated into existing curricula.

Although we have a government national policy toward family planning in Kenya, there are many opinion leaders who are not conversant with long- and short-term goals including the needs of family planning.

Priority Audiences

First priority

1. Elite and political
   - Executive and cabinet
   - members of Parliament
   - Senior civil servants

	Business and industrial leaders University professors and administrators
	2. Provincial and district elites Provincial Commissioner, District Commissioner All provincial and district heads of departments
	3. Health community Physicians Nurses Paramedical personnel Nutrition experts
	4. Communications media Newspaper editors Radio and TV programmers
Second priority	5. Clients of health services Women attending health clinics Men attending health clinics Women attending family planning clinics Husbands of women attending family planning clinics Postpartum women Dropout women
Third priority	6. General public Rural men Rural women Urban men Urban women
	7. Local leaders Local authority councillors Chiefs
	8. Non-medical field personnel Adult education officers Community development workers Social workers

Agricultural extension workers
Family planning personnel

9. Religious community leaders
   - Moslem
   - Christian
   - Nyanza indigenous
   - Local religious sects
10. Social groups
   - National Youth Service
   - Labor unions
   - Military and armed services
   - Women's groups
   - Voluntary agencies
   - Major employers
   - International agencies
11. Sex education
   - Educational personnel
   - Students and pupils

It is understood that individual persons may fall into several of the above categories.

Defining the Messages

When the planned program has progressed to the point that messages are being written, it is advisable that the skills of a journalist and of translators (and a simplified language) be utilized and employed on a part-time basis. However, before messages are written it is necessary that research be done on the knowledge, attitudes, and practices of various audiences. Suggestions for such research are set forth in the subsequent section on the work of the market research agency.

As guidelines for further development of messages, consideration was given to various audience categories and appropriate messages.

Elite and political This sophisticated audience needs to fully grasp the relationship between population growth and economic development, education, medical and social benefits, nutrition and food production, job opportunities, and general family health, as well as to be acquainted with the national policy and program on family planning.

Provincial and district elites The messages are the same as for elite and political. However, the messages should be directly related to provincial and district needs.

Health community The messages should reinforce a belief that family planning is important to family health, that family planning is a national policy, that it is an integral part of health services. Further, this audience must be kept abreast of developments in the family planning program.

Communications media This audience is in close contact with a major section of the general public and needs to be convinced of the importance of including family planning information and news in their media. The messages are similar to those for elite.

Clients of health services For women attending health clinics, the message is the advantages of family planning and the availability of family planning services. A similar message directed to men should be developed. For women attending family planning clinics the message should reinforce their acceptance of family planning and need for continuous contraceptive practice. A special "For Men Only" piece could be developed discussing the effect of large families on land division, school fees, food, and jobs.

General public There should be a continuing flow of messages on the benefits of family planning for family life and welfare. The messages should strive to create a general atmosphere of acceptance of family planning by the community and encourage individuals to adopt family planning practices. The messages should be simple, terse, and intimately related to the felt needs of the audience.

Local leaders For the general public to see that their local leaders speak the same language, this group should be encouraged to participate in the family planning program. The messages are similar to the general public.

Non-medical field personnel Messages similar to those aimed at the elite with emphasis on the relation of their work to family planning.

Religious community leaders Messages should strive to legitimize family planning by showing that contraceptive practices are compatible with religious teachings and beliefs.

Social groups This category covers a variety of audiences ranging from women's groups to business firms' employees. The intention here is to utilize the various organizational structures for

the dissemination of family planning information. The messages are similar to those for the general public.

Sex education This potential audience of teachers, students, and pupils should be considered independent of this plan. The teaching of human sexuality, family norms, and population problems is probably very important to the future development of Kenya and the acceptance of family planning. There is a need to develop school curricula and suitable teaching materials.

Defining the Media

Proper selection of media depends on knowledge of potential audiences and on the messages directed at these audiences. The skills of an advertising agency, for media selection, are being utilized; audience research results are also important.

In order to develop guidelines, subject to research results and advertising agency advice, media suggestions are made for the various audiences and messages profiled earlier.

Audience	*Messages*	*Proposed Media*
Elite and political	Population growth and its relationship to economic development, education, medical facilities, nutrition and food production, job opportunities, and general family health.	Print a series of six pamphlets, ten to twelve pages in length, each to be same size of similar design; will cover in detail topics listed under message. Radio and TV panel discussions. Newspapers–short feature articles. Films and discussions at public service clubs throughout the country and the United Kenya club in Nairobi.
Provincial and district elites	Population growth and its relationship to economic development, education, medical facilities, nutrition and food	Print, radio, TV and newspapers same as elite-political. Further, personal contacts should be made.

Audience	*Messages*	*Proposed Media*
	production, job opportunities, and general family health.	
Health community	Importance of family planning	Print–mail the series of pamphlets mentioned above for elites to this audience, approximately 2,000, utilizing the Ministry of Health's distribution facilities. Training courses and seminars where training courses are held–either at provincial district centers or in Nairobi. Lectures on the importance of family planning to health should be given.
	Developments in family planning	Newsletter–a bi-monthly news-bulletin should be developed. Its format should be simple and newsworthy and the production requirements inexpensive.
Communications media	Same as elite	A one-day seminar to present development problems; preferably a representative of Ministry of Economic Planning and Development should be key speaker. Frequent addresses to the Press Club at their luncheons. Personal contact–by the Executive Director and/or the Ministry of Health official in charge of family planning.

Audience	*Messages*	*Proposed Media*
Clients of health services	Advantages of family planning and availability of health services	Personal contact–by field workers, medical and paramedical personnel. Lectures–with appropriate teaching aids and a basic flipchart. Take home materials–pamphlets which reinforce the field workers' contact or the lecture. A pamphlet for men.
General public	Information motivation and acceptance of practices	For rural men and women radio, sound trucks, and the commercial mobile movie circuits can be used. For urban men and women the English and Swahili newspapers, and especially magazines, radio, and exhibitions. Posters and billboards could be used experimentally. Personal contact by field educators and non-medical field personnel.
Local leaders	Same as for general public	Seminars. Personal contact. Take home materials.
Non-medical field personnel	Same as elite	Similar to elite plus seminars at district and/or provincial level. Addresses at general meetings.
Religious community leaders	Legitimation in religious terms	Newspapers–articles for religious sections. Personal contact.

Audience	*Messages*	*Proposed Media*
Special groups	Similar to general public	Lectures–using films and audiovisual aids. Take home materials.

Where radio and television programs are called for, a part-time radio-TV consultant should be utilized for program development.

Utilizing Advisory Resources and Personnel

As previously mentioned, the Family Planning Association is responsible for development and implementation of an Information and Education program in coordination with the Ministry of Health Family Planning Program. (See Figure 1.) To develop the program plans in this report, the following types of expert advisory resources are anticipated: (1) a journalist; (2) translators; (3) an expert on simplified language; (4) a radio-TV program consultant; (5) an advertising agency; (6) a market research agency, perhaps assisted by a sociologist or psychologist.

The tasks proposed for each are:

Journalist Employed on a part-time basis to develop the text for printed materials, particularly the booklets prepared for the elite audience, to write news and feature articles for newspapers and magazines, and to prepare appropriate press releases. The International Planned Parenthood Federation Department of Information and Education will also be utilized.

Translators To translate prepared materials into vernacular languages.

Simplified Language Experts Messages for literate general public must be prepared using the simplest language and phrasing. Both the Ford Foundation and the government's Board of Adult Education can assist.

Radio–TV Program Consultant A person skilled in this type of program development could produce the proposed talk and panel shows. If possible, someone from the Voice of Kenya should be employed.

Advertising Agency The possibility of using Kenya Advertising Corporation was looked into and found to be too expensive. Instead, the Health Education Unit in association with the Department of Design at Nairobi University and possibly an advertising agency will be requested to:

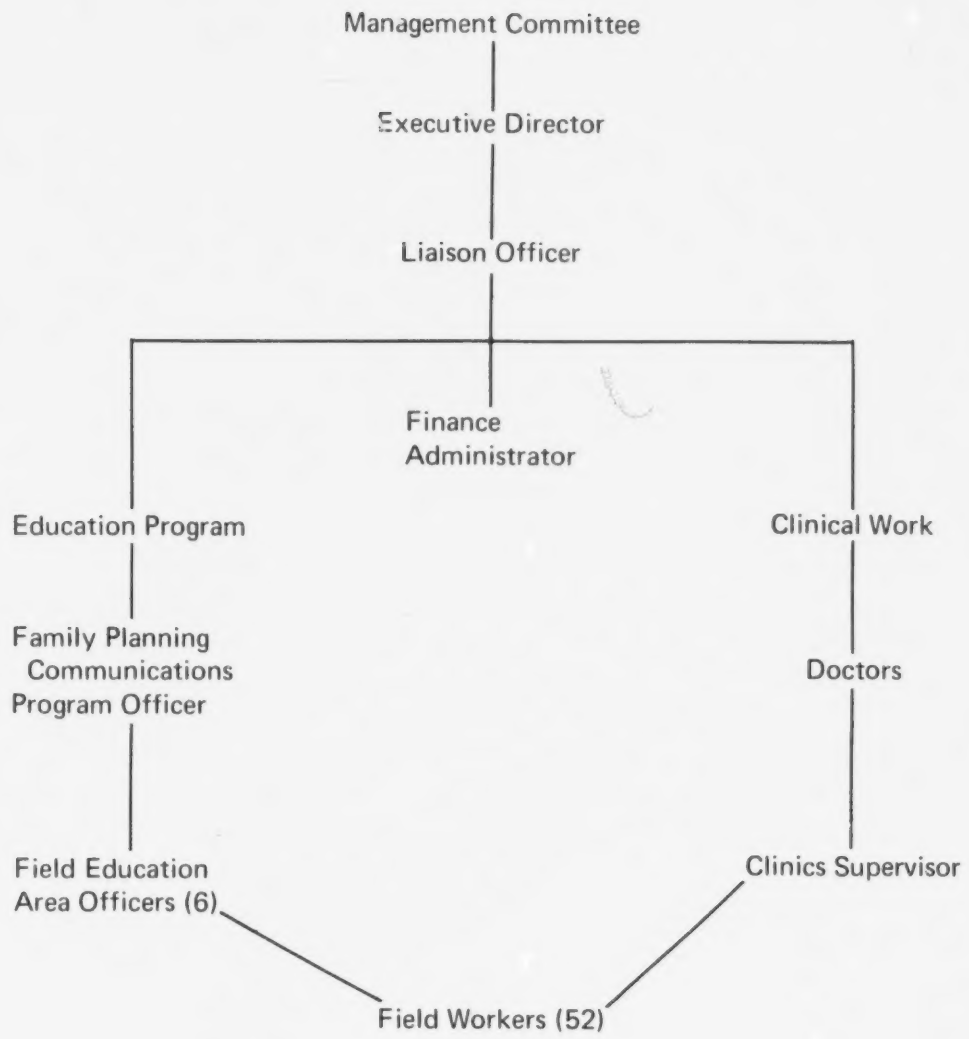


FIGURE 1 *Flow Chart of Family Planning Organization of Kenya*

1. Design and develop a family planning theme that can be used as a framework for all family planning information and education. It is suggested that they develop two or three symbols and slogans which could represent family planning in Kenya. These designs will then be given to the market research company to test their positive impact. A final design will be proposed for acceptance and use by all organizations involved in family planning.

They will also be asked to develop a design layout which could be used for all visual materials. The intention is that, over time,

the various family planning audiences of Kenya will come to identify a certain "look" as family planning, in much the same way we identify a certain look with "Coca-Cola" or with "Asproo." The same design should be recognizable on a pamphlet, a news-bulletin, or a cinema slide.

2. Design and develop program materials. When the media needs for the family planning program are decided, they will be asked to do such tasks as: develop newspaper advertisements; develop billboard advertisements; produce a film commercial for the mobile cinema; produce a visual opening and closing theme for TV programs; produce ten to sixty second radio commercials; and assist with the production of audiovisuals such as flipcharts, slides, and filmstrips.

3. Develop a media schedule for various family planning audiences, considering the various media proposals put forth above. Prepare a six-months and a one-year schedule for commercial media. Consideration should be given to newspapers, radio, mobile cinema vans, and sound trucks. Further, a pilot campaign could be considered for posters and billboards.

It is most important that, for any campaign directed at bringing the general public into family planning clinics, careful consideration be given to availability and degree of utilization of family planning clinic services. Media programs will be implemented only in areas where available services are underutilized. The Family Planning Association will offer continuing advice on service availability. Where there is full utilization of Family Planning Services, the field staff will concentrate on followup work.

Market Research Agency After a number of conversations with Associated Business Consultants, a market research agency which recently completed a countrywide survey for the government's Voice of Kenya, the agency was requested to submit study costs for the following projects:

1. Pretest proposed symbols and slogans. Which are understood by the greatest number of audiences from elite to rural women? Which have the most positive response? Which associate best with a family planning program? The agency is asked to carry out this study as soon as possible.

2. Survey the health community to ascertain present knowledge, attitudes, and practices of family planning. It is critical to know if any negative attitudes exist and to precisely identify such attitudes.

3. Survey the elite and political audience to ascertain their present knowledge, attitudes, and practices of family plan-

ning. However, the principal purpose of this study is to learn to what extent the audience perceives the relationship between population growth and health, jobs, education, food, and economic development.

4. Survey women attending family planning clinics. This study should show what questions about family planning women want to ask. Further, it should learn why a woman accepts family planning. The objective is to provide training for field workers on the issues which disturb women and to assist in developing educational materials.

5. Survey women who have discontinued family planning (dropouts) to learn what the reasons for starting and stopping were.

After considering the above projects, the agency proposed to submit a program which would undertake to answer all of the questions in one survey and, as an alternative, in a series of surveys of different audiences. Appropriate costs will be submitted for the alternatives.

It is anticipated that the market research agency will also undertake the testing of existing program materials, mostly printed matter, and the pretesting of new materials before they are put into use.

Consideration has been given to employment of a sociologist or social psychologist to consult with the agency on the development of questionnaires.

Training

The suggestions here are included in the belief that additional training inputs could be beneficial to the proposed program.

Program Officer A program officer was appointed in March 1970 and is proceeding on training as indicated in the work plan.

Field Workers Field workers should concentrate on clinic and extension education. It has been found useful to choose experienced field workers for additional training abroad.

Press Seminar A press seminar will be held in December in Nairobi for journalists and other media personnel. These one or two day seminars could discuss the population problem and its community implications.

Sex Education In an earlier part of the report the need for development of curricula to deal with population problems, human sexuality, and sex education was discussed. The Association is

in the process of preparing a booklet on sex education for possible use in secondary schools.

Other Training Possibilities The Visual Aid Centre in London conducts periodic courses in the development and use of educational aids. The Government of Tunisia has a SIDA consultant, Mr. Bjorn Berndtson, who is highly skilled in the development of family planning information and education materials. Both of the resources could be utilized as well as any other training opportunities that are available.

Monthly Work Plan

The following timetable is considered a desirable plan for development of an education and information program between June 1970 and December 1970. As there are many variables in program development, changes are inevitable.

JUNE 1970

1. Lectures to general public, schools and special groups to be continued. Program officer to proceed for training in family planning communication in Iran and at the University of Chicago.
2. Executive director, medical officer (family planning), and a health education officer to attend communications workshop in Iran.
3. Provincial medical officers and provincial matrons to attend a one-week family planning course in Nairobi. Fourteen new field educators to attend two-week course in family planning.
4. Talks and exhibitions, at agricultural shows, to the general public.
5. Prepare handouts.
6. Take home materials issued.
7. IPPF Office in Nairobi in the process of producing a pamphlet for the elite political group.

JULY 1970

1. Associated Business Consultants to carry out the KAP Study of the elite-political group as well as pretesting symbol and slogan.
2. Agricultural show exhibition seminar on research in family planning to be held in Nairobi.
3. Lectures to general public, schools, and special groups to continue. Seminars for local leaders (opinion leaders).
4. Press release on advantages of family planning.

5. Lecture to Press Club luncheon.
6. Happy Families Club radio program.
7. Medical officers to attend a one-week family planning course in Nairobi.
8. Followup of dropouts in a pilot area by field educators.
9. Organize television panel discussions.

AUGUST 1970

1. Start working out financial estimates for 1971.
2. Publicity–agricultural shows.
3. Lectures and seminars continue.
4. A field educator and a hospital matron to attend a family planning course in the Republic of Korea.
5. Happy Families Club program continues.
6. Mailing of pamphlet #1 to the elite-political and health communities and personal followup where possible.

SEPTEMBER 1970

1. Prepare exhibits at agricultural shows.
2. Lectures continue.
3. Plan seminars for paramedical and local leaders.
4. Call on TV and radio personnel to prepare panels.
5. Medical and paramedical personnel courses in family planning.
6. Prepare information for newspaper releases.
7. Finalize financial estimates for 1971.

OCTOBER 1970

1. Seminars and lectures continue.
2. TV panel discussion.
3. Press releases.
4. Exhibit at Nairobi show.
5. Three communications area officers to proceed to Accra for a two-week course in communications.
6. Article in a religious magazine (Target.)
7. Prepare pamphlet #2.
8. Explore possibilities for translators.
9. Question-and-answer press releases.

NOVEMBER 1970

1. Same as for September except for Nairobi Show.

DECEMBER 1970

1. Same as for September plus a one-day seminar for mass media personnel in family planning communications.

2. Mail pamphlet #2.

General Comments

1. Newsletter–a quarterly news bulletin will be developed during the planned period.

2. Results by the KAP and slogan/symbol study are expected during October. On the basis of this information, the advertising agency will undertake the design of the information program visual materials.

3. Opportunities to give lectures and show films and distribute take home materials to special groups during their regular meetings will be studied.

4. The above timetable covers a six-month period. Due to budgetary limitations and uncertainty of a future budget, it is presently unrealistic to develop a detailed monthly work plan for the year 1971. However, it should be noted that the objectives cover a period of at least five years, and it is planned that the work of the Family Planning Association of Kenya will continue.

WORK PLAN: SUDAN

A. R. KABBASHI

Objectives and Strategy

Objective To increase participation in existing family planning clinics by: (1) maintaining continued contraceptive use by present users; and (2) acquiring new users.

Strategy Improve quality and quantity of clinical services by: (1) increasing number of volunteering doctors; (2) increasing available supplies; and (3) training programs.

Objective To increase awareness of the population problem on a nationwide basis and to increase acceptance and demand in Medani City.

Strategy National information campaign on importance of family planning to economy, to well being of nation, family and individual. A secondary campaign directed at Medani.

Objective To increase the support for the association from the Ministry of Health and the Women's Union.

Strategy Presentation and justification of case for support.

Target	*Message*
Medical profession (three towns) Health visitors (three towns)	Report on activities of association, on increasing demand for services, and intention to intensify and expand services in the three towns to meet the demand. Our need for more doctors and health visitors helping us. Volunteer services to the public—we will arrange for training and orientation courses for them.
I.P.P.F. Pathfinder	Report on our activities and the increasing demand for more services by the public. Our intention to expand our activities. Request additional medical kits and contraceptive material, help in training doctors, and provision of a car.
Heath education personnel Ministry of Health	Express appreciation for help given to us so far, and indicate our need for extra time on radio and TV health programs.
Press Union	Express appreciation for assistance given to us and indicate that owing to our intention to increase our activities we might need more help from them in disseminating family planning information to the public.
Medical profession Paramedicals (Medani)	Report on activities and success we have achieved in the three towns through volunteer doctors and paramedicals. Our decision to start a clinic in X Health Center under the supervision of Dr. X. Appeal to them to disseminate the word to all couples they come in contact with in hospitals, private clinics, and health centers. Ask for participation on a voluntary basis.

Local Women's Union (Medani)	Convey decision to start a clinic in Medani in response to their request and that Dr. X will be responsible. Appeal to them (1) to cooperate with Dr. X by distributing information to mothers urging utilization of the service and (2) to volunteer for secretarial and reception work in the clinic.
Minister of Health Department of Preventive and Social Medicine University of Sudan	Present up-to-date report on activities. Express appreciation for support given to us. Indicate increasing demand put on us and our intention to intensify and expand our activities in the three towns and start a clinic in Medani. We need to use three more centers in the three towns and one center in Medani. Explain that we badly need help in transporting some volunteers from homes to centers and back and that we lack facilities; request the Ministry's help.
National Women's Union Committee	Report on activities and the increasing demand on our services. State our need for more volunteers for the additional work we intend to carry out. Request their help in disseminating information about new clinics.

Annual Work Plan

MONTHLY

1. A fortnightly radio program addressed to the public to increase their awareness of the population problem and the benefits of family planning from economic, social, and health aspects, and asking for more participation in available services. Emphasis varies from month to month.

2. A monthly TV program explaining the benefits of family planning and describing the available services in the three towns.

3. A monthly newspaper article on the population problem, the needs and benefits of family planning with emphasis varying from month to month.

4. A monthly statistical report to be compiled by each clinic on the number of users, their characteristics, the methods used, dropouts, location, material used and so on, to enable the executive committee to compile a monthly and later an annual report to the Council.

SEMI—ANNUALLY

To conduct twice yearly basic training courses for health visitors and nurse/midwives to encourage promotion of family planning during their routine health work.

ANNUALLY

1. Compilation of annual report.
2. Preparation of an up-to-date mailing list for gynecologists and health visitors in Khartoum Province and in Medani town.
3. Letter and budgetary request to IPPF.
4. Letter and budgetary request to Pathfinder Fund.
5. Meeting with Minister of Health, under-secretary, and PMOH Khartoum Province—to be preceded by a letter and a report on Association activities.
6. Letter to National Women's Union Committee.
7. Meeting with the National Women's Union Committee.
8. Letter, followed by a meeting, with Women's Union, Medani.
9. Organization of training programs for new volunteers in Khartoum and in Medani.
10. Meeting with midwives in Medani Town—preceded by a letter to Superintendant of Midwifery, Medani.
11. Meeting with Sudan Medical Association Committee.
12. Annual Council Meeting.
13. Inform potential users of services and schedules at new clinics and old ones.
14. Contact Health Education Division for help in preparation and production of necessary information material such as posters and leaflets.
15. Participation in the annual meetings of the Sudan Medical Association and affiliated societies to motivate members to take a more positive position on family planning and utilization of all opportunities to offer services and to educate people.

Monthly Work Plan

JULY 1970

1. Organize radio and TV programs and newspaper article for the month.

2. Send pro forma for monthly statistical report to all clinics.

3. Compile annual report for 1969–1970 and distribute to members of Council, members of the profession, and relevant organizations; utilize for publicity programs.

4. Begin work on an up-to-date mailing list for gynecologists, general practitioners, and health visitors in Khartoum province and Medani Town.

5. Write a letter to secretary, Sudan Medical Association, to make an appointment for delegates from family planning executive committee to meet with SMA committee. Delegates will request the committee to support their appeal to doctors for voluntary services.

AUGUST 1970

1. Organize the radio and TV programs and newspaper article for the month.

2. Collect statistical reports for July.

3. Make necessary preparations for training course for health volunteers and nurse/midwives due in September in Khartoum.

4. Submit budget for communication, education, and training.

5. Send letters to all gynecologists, general practitioners, and health volunteers in Khartoum and Medani describing last year's activity and indicating the increasing demand for our services and our need for their help.

SEPTEMBER 1970

1. Organize radio and TV programs and newspaper article for the month.

2. Collect and compile statistical report for August.

3. Conduct the training course for health volunteers and nurse/midwives.

4. Send annual report and Association's budgetary request to IPPF and Pathfinder Fund.

5. Make arrangements for training course for new volunteer doctors and health volunteers in Khartoum.

OCTOBER 1970

1. Organize radio and TV programs and newspaper article for the month.

2. Collect and compile statistical report for September.

3. Conduct training course for new volunteers in Khartoum.

4. Complete any unfinished work from previous months.

NOVEMBER 1970

1. Organize radio and TV programs and newspaper article for the month.

2. Compile statistical report for October.

3. Prepare for training of new volunteers in Medani.

4. Make an appointment and meet the Minister of Health, U.S. preventive and social medicine personnel, and PMOH, Khartoum. Discuss last year's activities and plan for intensification of work and help required from Ministry.

DECEMBER 1970

1. Organize radio and TV programs and newspaper article for the month.

2. Compile statistical report for November.

3. Conduct a training course in Medani for doctors, health volunteers, midwives, and the like.

4. Contact Health Education Division and jointly design and prepare posters for use in the new clinics as well as material on family planning and the work schedules of new clinics.

JANUARY 1971

1. Organize radio and TV programs and newspaper article for the month.

2. Compile statistical report for December, 1970.

3. Distribute prepared material to health centers and clinics and to personnel, including midwives, in the districts in Khartoum and Medani.

4. Meet with Women's Union Committee in Khartoum; discuss achievements of Association and ask for more volunteers.

5. Write to Women's Union, Medani, of our intention to visit Medani to prepare for work in new clinic.

FEBRUARY 1971

1. Organize radio and TV programs and newspaper article for the month.

2. Compile statistical report for January.

3. Prepare for second training course for health volunteers and nurse/midwives.

4. Meet with Women's Union, Medani, to plan for work and necessary publicity.

5. Meet with medical and paramedical personnel in Medani and inform them of the arrangements.

6. Arrange for a joint meeting between medical and paramedical personnel and Committee of Women's Union to discuss and organize a joint campaign in Medani to publicize services and educate citizens about family planning.

MARCH 1971

1. Organize radio and TV programs and newspaper article for the month.

2. Compile statistical report for February.

3. Conduct training course for health volunteers and nurse/midwives in Khartoum.

APRIL 1971

1. Organize radio and TV programs and newspaper article for the month.

2. Compile statistical report for March.

3. Complete unfinished tasks.

MAY 1971

1. Organize radio and TV programs and newspaper article for the month.

2. Compile statistical report for April.

3. Contribute to the Annual Women's Union meeting—read a paper and distribute material on population problem and benefits of family planning to the family. Ask a prominent woman leader to speak about family planning.

4. Complete any unfinished tasks from previous months.

JUNE 1971

1. Organize radio and TV programs and newspaper article for month.

2. Compile statistical reports for May and June.

3. Participate in the annual obstetricians and gynecologists meeting. Describe the work of the Association and appeal to obstetricians to lend more support to family planning activities and to spread the message to couples during routine checkups.

4. Begin work on annual report (1970–1971) and outline series of informational materials for general distribution to be developed from the report.

WORK PLAN
UNITED ARAB REPUBLIC

NAWAL EL SAADAWI, NADIA KHAIRY
AND MOHAMMED KHAZBAK

Objectives and Strategies

1. To convince opinion leaders to increase their support of family planning programs.

Strategy To have more active governmental support, it is necessary to inform opinion leaders regularly of the program's progress, plans, goals, and achievements.

2. To increase the number of attendants in family planning units in urban and rural centres but especially in rural areas.

Strategy In order to have more support and action from groups who can provide access to large numbers of potential acceptors especially in rural areas (women's groups, union labourers, farmers, teachers), we should inform them continuously about aspects of family planning to increase acceptance of the idea among both rural and urban public in general and non-participants in particular.

To continue the information program in the whole country with emphasis on the rural areas because:

a. The idea of family planning is not generally opposed in urban and rural areas.

b. The National Family Planning Program is four years old, and the government supports it strongly.

c. The mass media, especially radio, are quite prevalent in urban as well as in rural areas.

d. Religious leaders support the program.

3. To build family planning concepts into the way of life of younger generations.

Strategy Family planning is a new way of life. It is important to educate secondary school students on the benefits of family planning.

Target Groups

First Priority

1. Elite and political
   Executive Cabinet members
   Members of the National Council (Parliament)
   Members of the Central Committee of the Arab Socialist Union
   University professors
2. Provincial elites
   Governors and Members of Governorates' Councils
   Secretaries of the Arab Socialist Union in Governorates
   Chairmen of town councils
3. Communications media
   Newspaper editors
   Radio and TV administrators and programmers
4. Religious leaders
   Muslim
   Christian

Second Priority

1. Opinion leaders
   Leaders of the Arab Socialist Union at different levels
   Newspaper editors
   Radio and TV programmers
   Religious leaders (Muslim and Christian)
2. Health community
   Physicians (in family planning units)
   Nurses (in family planning units)
   Social workers (in family planning units)
3. Religious leaders at local levels
4. Special groups
   Labour unions
   Women's associations
   Women attending health clinics
   Dropout women
   Postpartum women
   Primary school teachers
   Members of basic units of ASU

Third Priority

1. Ministry of Education and high officials in the Ministry

Proposed Messages

First Priority

1. Elite and political This group needs continuous information about the relation between rapid population increase and economic development. Also, the effect of rapid increase on the education, health, and economic conditions of the population.

2. *Provincial elites* This group needs continuous information about the relation between rapid population increase and economic conditions of the people in their governorate.

3. *Communications media* Message is similar as to the elite. They also have to be reminded of their influence on the people.

4. *Religious leaders* To assure people that family planning is approved by religion.

Second Priority

1. *Opinion leaders* To continuously remind them that family planning is a national responsibility and that it is their duty to persuade the people to practice family planning and to attend family planning units.

2. *Health community* To stimulate the members of this community to improve quality of service and especially to change their behavior toward clinic participants.

3. *Religious leaders at local levels* To assure that family planning is approved by religion, and to remind them of approval of the national religious leaders.

4. *Special groups* The message will differ from one group to another.

a. Laborer Unions: Discuss the effects of rapid population increase on labor conditions–unemployment and increase of non-trained laborers.

b. Women's associations: The message will concentrate on what repeated pregnancy does to a women's beauty and health. Also, emphasize the physical and psychological burdens of having too many children.

c. Women attending health clinics: The same messages plus some information about treatment, care, side-effects.

d. Dropout women: The same message with special emphasis on problems causing them to dropout.

e. Postpartum women: The same message, with special emphasis on postpartum care.

f. Primary school teachers: Remind them of their influence on the people in villages and that they are (nearly) the only educated people in the villages, also remind them of their responsibility toward the illiterates.

g. Members of the basic units of ASU: Tell them that motivation on family planning is a political and national responsibility which they have to accomplish.

Third Priority

Ministry of Education — The message will be to convince responsible persons in the Ministry that population problems and family planning should be included in the regular high school curricula in order to convince young people of the necessity for family planning.

Work Plan

ANNUAL

1. Reorganize the Department of Motivation and Information. It will contain divisions for: Information and Writing, Publication–Movie and Stage, Governorates' Division. Additional staff should be recruited.

2. Reorganize the consultative committee for motivation in order to include members from the different sectors concerned with motivation.

3. Cover all essential roads and railway stations with billboards and trains and other transportation means with posters emphasizing the benefits of family planning.

4. Write and publish a unified booklet on aspects of family planning. This booklet will be distributed to all participants in family planning activities, especially in communication fields.

5. A wide distribution of posters all over the country.

6. Distribution of various pamphlets on different family planning aspects (by the units).

7. A conference on family planning aspects for all those who are interested. An intensive persuasive campaign by all communications media to be held twice a year.

8. Designate a special week for family planning; publicize it through a special program.

9. Set up committees on different local levels for motivation of the people especially by mouth-to-mouth communication.

10. A lecture to be prepared (on broad lines) and to be distributed to Centers of Labourers' Cultural Association (literature and information about clinics).

11. Contact the Ministry of Education and the Ministry of Higher Education about preparation of the educational programs.

12. Contact the Higher Committee of Health Education to coordinate activities.

QUARTERLY

1. A pamphlet on the population problem and family planning activities should be distributed to people working in mass communications media. The pamphlet will be accompanied by a letter inviting them to assist the Family Planning Program by speaking and writing about family planning.

2. Publish a magazine on family planning activities to be distributed to all family planning personnel and communicators.

3. Begin a training course on radio and TV programs to different groups of staff participating in family planning activities. (The course would be changed every three months.)

4. Produce four short films (one each quarter).

5. Daily radio and TV spot announcements to be changed every three months.

6. Brief messages in newspapers (to be changed quarterly), to run perhaps as often as once a week.

MONTHLY

1. One article—at least—should be prepared on the relation between rapid population increases and economic development. It will also emphasize the relationship between rapid increase and economic conditions of the people.

2. One monthly discussion on the effect of rapid population increase should take place on radio and TV programs. These discussions could be included in programs already broadcasted regularly.

3. Reportage on different aspects of family planning activities should appear monthly in magazines with wide circulation.

4. A monthly family planning session should be held in schools for students' parents.

5. Monthly meetings should be held for the communications experts working in the governorates to discuss different problems encountered and ways to solve them.

WORK PLAN
ISHFAHAN COMMUNICATIONS PROJECT

MEHDI LOGHNANI, WILBUR SCHRAMM,
AND ROBERT GILLESPIE

This paper will act as a status report on the Ishfahan Communications Project. Naturally the project will not be able to encompass all the recommendations that have been made. Many local factors have had to be considered such as existing family planning policy, extent of contraceptive services, and available personnel.

Objectives

The mandate has been to conduct an intensive communications project and to evaluate the effect by measuring increases in family planning acceptors and changes in knowledge and attitudes. To do this the following objectives will be pursued:

1. To conduct a before-and-after base-line survey of knowledge, attitudes, and practices of family planning as well as media exposure.
2. To measure rates of acceptance at the clinics before and after the experimental treatments; and after three months.
3. To determine present family planning activities and potential use of functionaries such as literacy corps, school teachers, mullahs, village leaders, midwives, health corps girls, health corps doctors, private doctors, pharmacists, and agricultural extension workers.
4. To pretest and produce radio programming, newspaper and magazine advertisements, cinema film clips, posters, mailings, leaflets, exhibits, and bus panels.

5. To conduct a campaign to use radio for three months then combine it with all other mass media for three months.

6. To select two shahrestans where the potential use of functionaries will be tested.

7. To select a few blocks in Ishfahan city along with two or three villages to conduct a maximum effort using full-time family planning workers and functionaries conducting home visits and group meetings.

8. To determine what can be done to increase continuous use of contraceptives by distributing more cycles at one time, by setting more distribution points, and by followup of acceptors who do not return.

9. To find out what kinds of problems arise for administrators, supervisors, and field workers in conducting an intensive campaign, these workers will be asked to keep diaries during the campaign.

10. To select twenty or thirty persons in the Ostan who will keep diaries of daily communication of both favorable and unfavorable information concerning family planning, in an effort to find out about the flow of interpersonal communication in such a campaign.

Current Activities

Questionnaires for functionaries will ascertain such characteristics as age, education, and material status, as well as working relations with other functionaires, exposure to mass media, and knowledge, attitude, and practice of family planning. Revolutionary Corps members who have had some family planning training will be asked to evaluate training and current participation in the family planning program. The final section of the questionnaire will explore potential participation of the functionaries in the program.

Sample of Functionaries

The samples of school teachers and literacy corps were stratified to represent rural and urban, primary and secondary, and female and male teachers. The sample sizes ranged from of the school teachers to 100 per cent of Health Corps doctors and Health Corps girls. Fifteen of the Health Corps girls have volunteered to do interviewing. Training given these interviewers covered the problems of bias, non-response, and filling out the questionnaires. After conducting three interviews in the classroom the interviewers started to work. Discussions with some of the

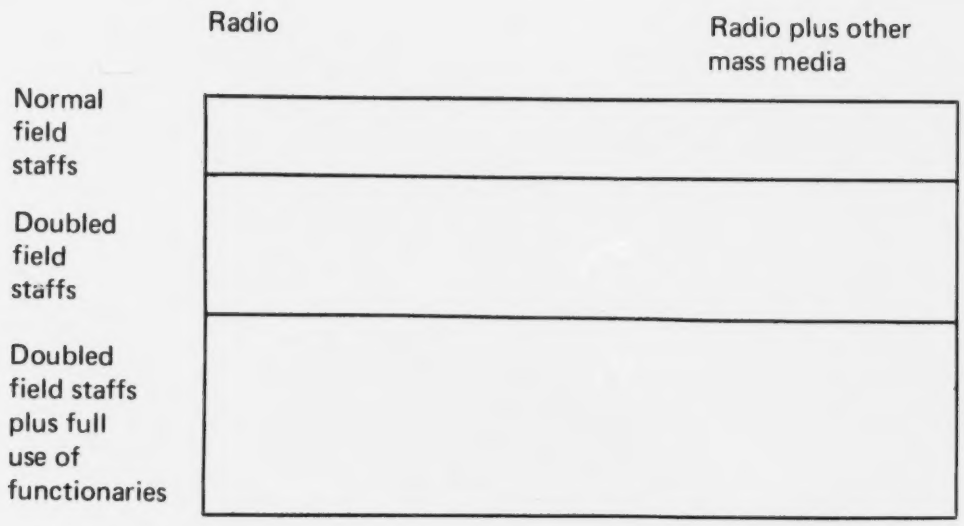


FIGURE 1 *Main Experimental Design*

teachers interviewed and a check of the returned questionnaires, indicated the surveying was progressing satisfactorily. To determine possible bias a scatter plot diagram will be drawn to see if there is correlation between knowledge and attitudes of interviewer and interviewees.

The first experimental input will begin during the middle of August. For three months, the radio will have ten sixty-second spots a day and two or three five-minute announcements weekly. The five-minute announcements will consist of statements by the governor, health director, family planning director, and other prominent leaders. In addition, there will be testimonials by satisfied users.

By the first of September, two shaherstans, or districts, with populations of about 200,000 will have functionaries recruiting cases. The functionaries who will be used are school teachers, literacy corps, agricultural extension workers, village leaders, midwives, Health Corps doctors and assistants, mullahs, and home economics agents. The inputs will be operational and acceptance targets will be (group meetings, home visits, and minimum

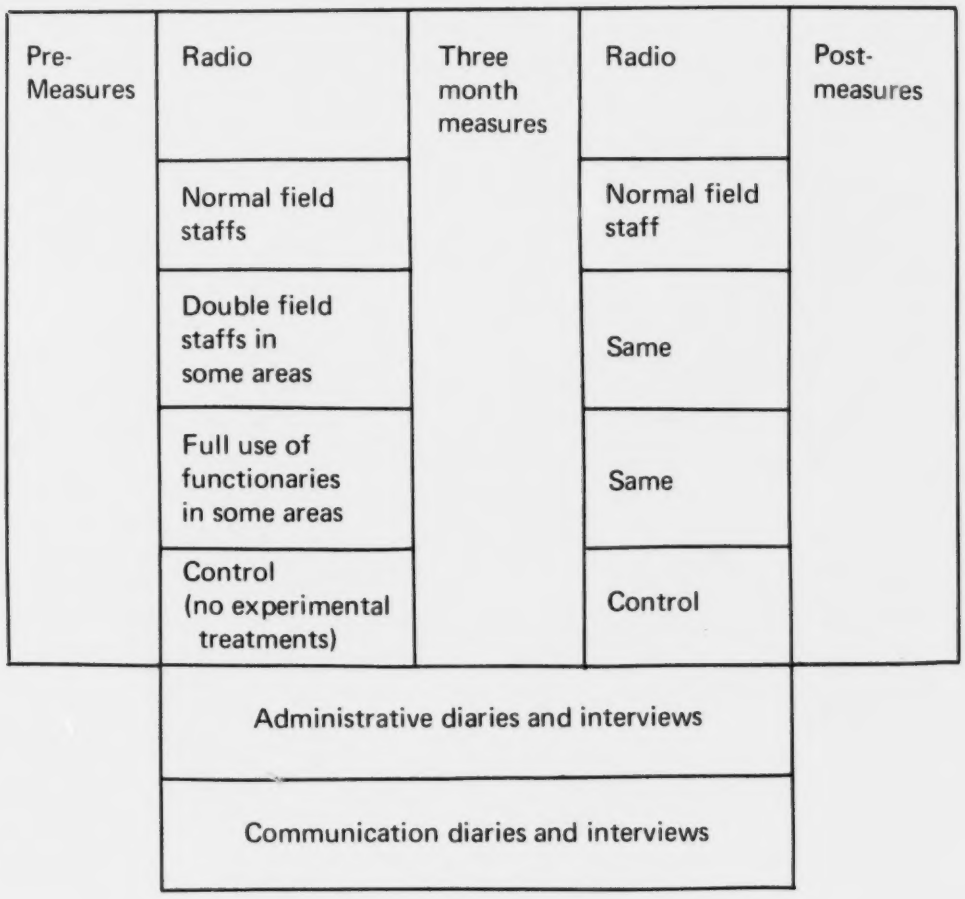
referrals) training, distributing contraceptives, distributing leaflets, and supervision.

A sector of five blocks in Ishfahan City along with three villages outside the city will be chosen for a maximum effort campaign. Besides mass media and functionaries, six full-time field workers and ten Health Corps girls will be assigned to the campaign.

Each household will be paid as many as five or six visits, and the men and women may attend two or three group meetings. A map of these areas will be drawn listing each household and the present family planning status. The criteria for evaluation will not only be use of contraceptives but desired family size.

Beginning in November, all other available media will be used, such as billboards, bus panels, mailings, posters, cinema film clips, and leaflets. Only the two control areas will not have this input. Although the relative impact of the individual media cannot be

FIGURE 2 *Time Schematic*



fully determined, both in the after survey and at the clinic a paired comparison technique will be used to give a rough gauge of influence.

Time permitting, an attempt will be made to determine ways of increasing continuous use. Providing three or four packets of pills at one time, using depot distribution, and conducting followup visits will be used.

Besides a before-and-after survey, an analysis of clinic attendance and a followup of a sample of acceptors, (about twenty people will be selected to record in diaries what they have seen and learned about family planning) will be conducted in an effort to determine specific program effects. Both positive and negative reactions will be recorded in the diaries.

In February 1971, the after survey will be conducted, and final analysis should be ready by April. Another survey in mid-1972 will determine effects on the birth rate through continuous use of methods.

Monthly Work Plan

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Functioning questionnaire	xxx	x									
Before KAP	xxx	xxx	x								
Pretesting	xxx	xxx	xxx								
Radio programming			xx	xxx	xxx	xxx	xxx	xxx			
Use of functionaries				xxx	xxx	xxx	xxx	xxx			
Intensive project				xxx	xxx	xxx	xxx	xxx			
Use of all other mass media						xxx	xxx	xxx			
Complete campaign									xxx		
After Survey									xxx	xxxx	
Start training staff in other Ostans									xxx	xxx	
Followup acceptors						xxxx			xxx	xxxx	xxx
Write up final report											xxxx

APPENDICES

APPENDIX A

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APPENDIX B

CONFERENCE PROGRAM

SCHEDULE

June 6, 1970 through June 18, 1970

June 5 (Friday)

12:00 Noon–6:00 P.M.
REGISTRATION

June 6 (Saturday)

9:30 AM–12:00 Noon
(Plenary Session)
OPENING CEREMONIES

All sessions will be held at the Labor Ministry Building, next to the Royal Teheran Hilton Hotel, Pahlavi Avenue, Teheran

2:30 PM–5:30 PM
(Plenary Session)
COUNTRY REPORTS

Each delegate will prepare a ten minute presentation covering:

(a) Description of population policy
(b) Family planning activities
(c) Information and education program
(d) Special communication problem

June 7 (Sunday)

9:00 AM–12:00 Noon
(Plenary Session)
PROGRAM REPORTS

2:30 PM–5:30 PM
(Group Sessions)
SIMULATION EXERCISE ONE:
Developing an Information and Education Program for Arcadia

Resource Advisors
Farsi:
Eng. R. Ghotbi
Mr. Amir Ahmadi

Dr. K. Asayesh
Dr. A. Zahedi
Dr. G. H. Jalali
Mr. A. Ghafoori

French:
Mrs. Francis Dennis
Dr. Dorothy Speed
Mr. Bjorn Berndtson

English:
Dr. Abdel Omran
Dr. Isam Nazer
Dr. Wilbur Schramm
Dr. Lyle Saunders
Dr. John K. Friesen
Mr. Robert Gillespie
Mr. Theodore Crane
Dr. Wesley H. Wallace
Mrs. Suzanne Wolfe
Mr. Robert R. Blake

June 8 (Monday)

9:00 AM–10:30 AM
(Plenary Session)
RELIGION AND FAMILY PLANNING

Dr. Abdel Omran
Carolina Population Center
Chapel Hill, N.C.

PANEL DISCUSSION

GENERAL DISCUSSION FROM FLOOR

11:00 AM–12:00 Noon
(Group Sessions)
SECOND SIMULATION EXERCISE: Developing an Information and Education Program for Valhalla

2:30 PM–5:30 PM
(Group Sessions)
COMPLETE SECOND SIMULATION EXERCISE

June 9 (Tuesday)

9:00 AM–10:30 AM
(Plenary Session)
WHY DOESN'T THE AUDIENCE MORE OFTEN DO WHAT WE WANT IT TO DO

Dr. Wilbur Schramm
Insititute of Communication Research
Stanford University
Stanford, California

PANEL DISCUSSION

GENERAL DISCUSSION
FROM FLOOR

11:00 AM-12:00 Noon
(Plenary Session)
GENERAL DISCUSSION ON
PROCEDURES FOR
DEVELOPING COUNTRY
INFORMATION
WORK PLANS

Robert R. Blake
Carolina Population Center
University of North Carolina
Chapel Hill, North Carolina

2:30 PM–5:30 PM
(Group Sessions)
GROUP WORK ON DE-
VELOPMENT OF
COUNTRY WORK PLANS

June 10 (Wednesday)
9:00 AM–10:30 AM
(Plenary Session)
EFFECTS OF MASS MEDIA
ON BEHAVIOR

PANEL DISCUSSION

GENERAL DISCUSSION
FROM FLOOR

Dr. Wesley H. Wallace
Department of Radio,
Television and Motion Pictures
University of North Carolina
Chapel Hill, N.C.

11:00 AM–12:00 Noon
(Plenary Session)
FILM SHOWING: "Family
Planning on Taiwan"
"Family Planning: The Louis-
iana Model"

2:30 PM–5:30 PM
(Group Sessions)
CONTINUE GROUP WORK
ON DEVELOPMENT
OF COUNTRY WORK PLANS

June 11 (Thursday)
9:00 AM–10:30 AM
(Plenary Session)

AN INTENSIVE NATION-WIDE TRAINING PROGRAM FOR COMMUNICATIONS AND RESEARCH

Dr. A. Zahedi
Ministry of Health
Government of Iran

PANEL DISCUSSION

GENERAL DISCUSSION FROM FLOOR

11:00 AM–12:00 Noon
FILM SHOWING: "Family Planning" (Disney)
"A Great Problem" (India)

2:30 PM–5:30 PM
(Groups Sessions)
GUIDED TOUR TO GOLESTAN PALACE AND CROWN JEWELS

June 12 (Friday)
HOLIDAY

June 13 (Saturday)
9:00 AM-10:30 AM
(Plenary Session)
COMMUNICATION STRATEGY AND EVALUATION

Dr. Lyle Saunders
The Ford Foundation
New York, New York

PANEL DISCUSSION

GENERAL DISCUSSION FROM FLOOR

11:00 AM–12:00 Noon
(Group Sessions)
CONTINUE WORK ON DEVELOPMENT OF COUNTRY WORK PLANS

2:30 PM–5:30 PM
(Group Sessions)
CONTINUE WORK ON DEVELOPMENT OF COUNTRY WORK PLANS

June 14 (Sunday)

9:00 AM–10:30 AM
(Plenary Session)
FIELD DEMONSTRATION AREAS

Mr. Robert Gillespie
The Population Council
Ishfahan, Iran

PANEL DISCUSSION

GENERAL DISCUSSION FROM FLOOR

11:00 AM–12:00 Noon
(Group Sessions)
CONTINUE WORK ON DEVELOPMENT OF COUNTRY WORK PLANS

2:30 PM–5:30 PM
(Group Sessions)
CONTINUE WORK ON DEVELOPMENT OF COUNTRY WORK PLANS

June 15 (Monday)

9:00 AM–10:30 AM
(Plenary Session)
PLANNING AND PRODUCTION OF PRINTED MATERIALS

Mr. Bjorn Berndtson
Swedish International Development Authority
Tunis, Tunisia

PANEL DISCUSSION

GENERAL DISCUSSION FROM FLOOR

11:00 AM–12:00 Noon
(Group Sessions)
CONTINUE WORK ON DEVELOPMENT OF COUNTRY WORK PLANS

2:30 PM–5:30 PM
CONTINUE WORK ON DEVELOPMENT OF COUNTRY WORK PLANS

June 16 (Tuesday)

9:00 AM–10:30 AM
(Plenary Session)
POPULATION EDUCATION IN PUBLIC SCHOOLS

Dr. John Friesen
The Population Council
Teheran

PANEL DISCUSSION

GENERAL DISCUSSION FROM FLOOR

11:00 AM–12:00 Noon
FILM SHOWING: "Human Reproduction"
"Population Ecology"

2:30 AM–5:30 PM
(Group Sessions)
EACH GROUP WILL GO THROUGH THE PROCESS OF WRITING A PRESS RELEASE, A PERSUASIVE LETTER ADDRESSED TO ELITE AND POLITICAL LEADERS, AND A RADIO SPOT ANNOUNCEMENT WHICH WILL BECOME A PART OF THEIR ANNUAL WORK PLAN.

June 17 (Wednesday)

9:00 AM–10:30 AM
(Plenary Session)
FIVE LESSONS LEARNED FROM FAMILY PLANNING COMMUNICATION PROGRAMS

Dr. Wilbur Schramm
Institute of Communication Research
Stanford University
Stanford, California

PANEL DISCUSSION

GENERAL DISCUSSION FROM FLOOR

11:00 AM–12:00 Noon
(Plenary Session)
COUNTRY REPORTS

Each country team will present brief ten minute descriptions of major communication activities planned for coming year.

2:30–5:30 PM
(Plenary Session)
COMPLETE COUNTRY
REPORTS

June 18 (Thursday)
9:30 AM–12:00 Noon
(Plenary Session)
FINAL CLOSING
CEREMONIES

APPENDIX C

PAPERS PRESENTED AT TEHERAN

Berndtson, Bjorn. (Communications Expert, SIDA) "A First Priority: Family Planning Communication Through Printed Material. Requirements for Preparation and Production of Printed Material."

Crane, Theodore R. (Chief, Special Reports Division, U.S. Department of Agriculture) "On Looking Forward While Working Backwards."

Friesen, John K. (Representative in Iran, The Population Council) "Population Education in Public Schools."

Gillespie, Robert. (Consultant, The Population Council, New York) "Field Demonstration Projects."

Khatamee, Masood. (Director of Training, Family Planning Division, Ministry of Health, Teheran, Iran) "Family Planning Education and School Curriculum in Iran."

Omran, Abdel Rahim. (Associate Professor of Epidemiology, School of Public Health, University of North Carolina at Chapel Hill) "Epidemiologic, Sociologic and Theologic Aspects of Muslim Fertility."

Saunders, Lyle. (Program Officer, The Ford Foundation, New York) "Family Planning Communications in the Context of National Development: Communications for Information and Motivation in Family Planning."

Schramm, Wilbur. (Director, Institute for Communication Research, Stanford University, Stanford, California) "The Things We Know About Family Planning Information."

_____. "Why Doesn't the Audience Always Do What We Want It to Do?"

Wallace, Wesley H. (Professor of Radio, Television and Motion Pictures, University of North Carolina at Chapel Hill) "The Uses of Radio in Family Planning Programs."

Webster, Lyle. (Communications Institute, East-West Center, University of Hawaii) "Some Guidelines for Supplying News to the Press."

Zahedi, A. (Family Planning Division, Ministry of Health, Iran) "An Intensive National Training Program for Communication and Motivation."

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